FY 2019 Proposed Budget *and* Financial Plan

A FAIR SHOT

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

DHCF Proposed FY2019 Budget, Including Medicaid and Alliance Spending Trends

Presentation for:

Base Budget Presentation

April 2018
Washington DC

Department of Health Care Finance

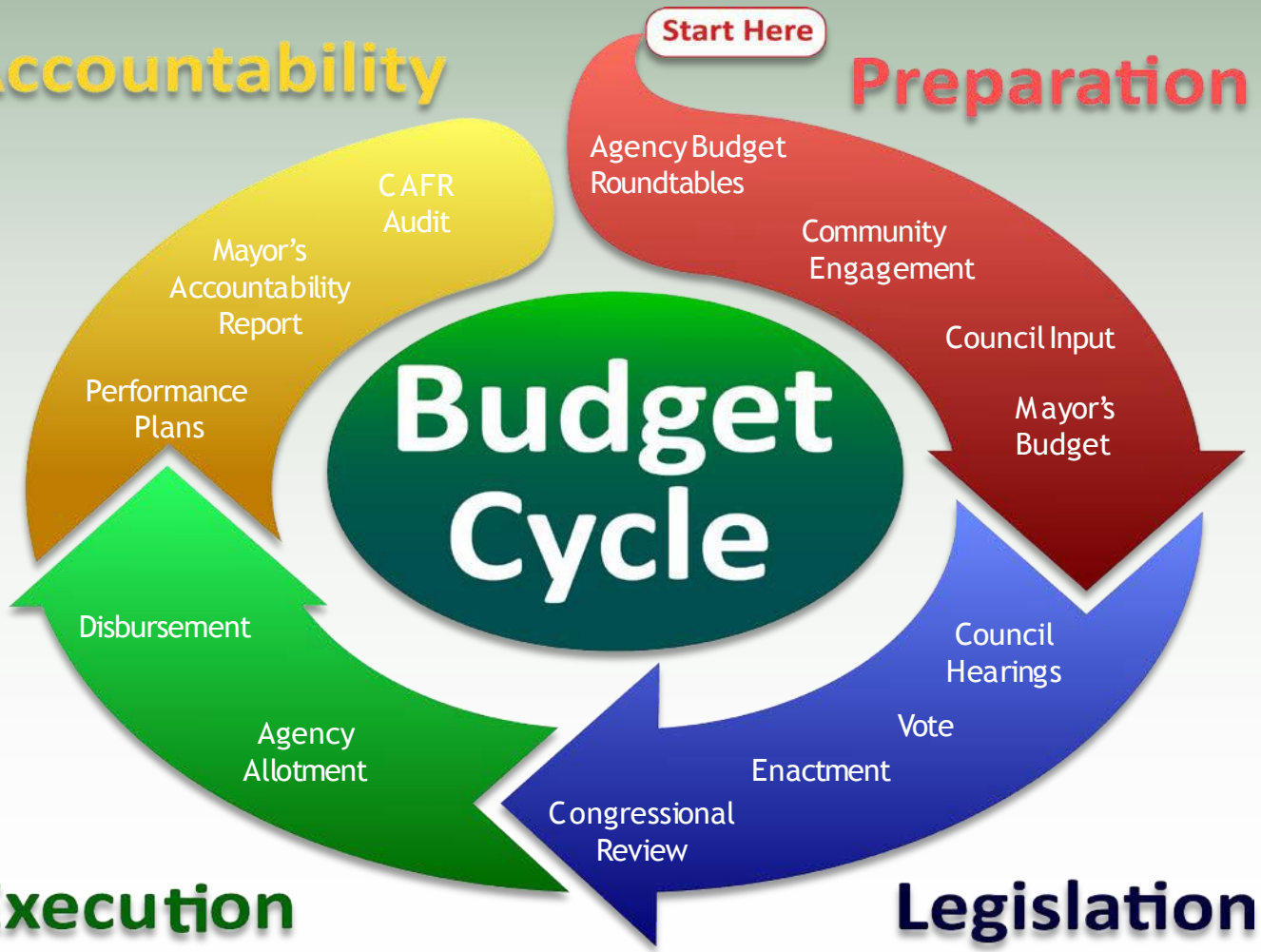
Presentation Outline

- ☑ **Overview Of District's Budget For FY2019**
- ☐ Budget Development For DHCF
- ☐ Medicaid Eligibility and Enrollment Trends and Systems Changes
- ☐ Alliance Enrollment and Cost Trends
- ☐ Medicaid Program Trends
  - *Managed Care*
  - *Fee-For-Service*
  - *Long-Term Care*
- ☐ Medicaid Innovations and Potential Future Impacts of Federal Legislation
- ☐ Next Steps With United Medical Center
- ☐ Conclusion

Mayor's Priorities

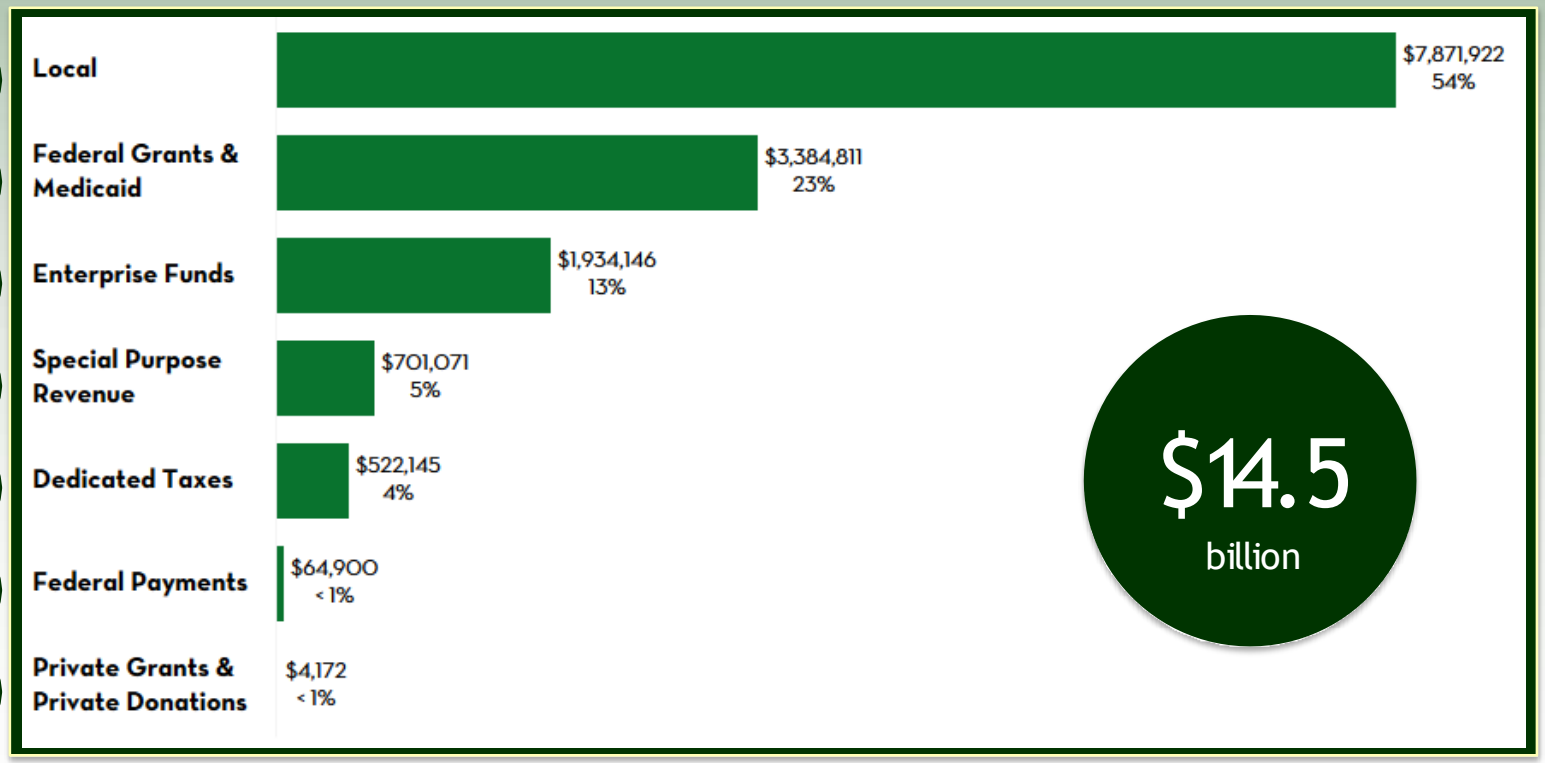
- Substantial investments in Infrastructure & Community Spaces
- Expand reach of Health & Human Services
- Accelerate achievements in Education
- Ensure access to Jobs & Economic Opportunity
- Increase access to Affordable Housing
- Increase investments in Seniors
- Strengthen Public Safety

Budget Process



Total Budget: Sources

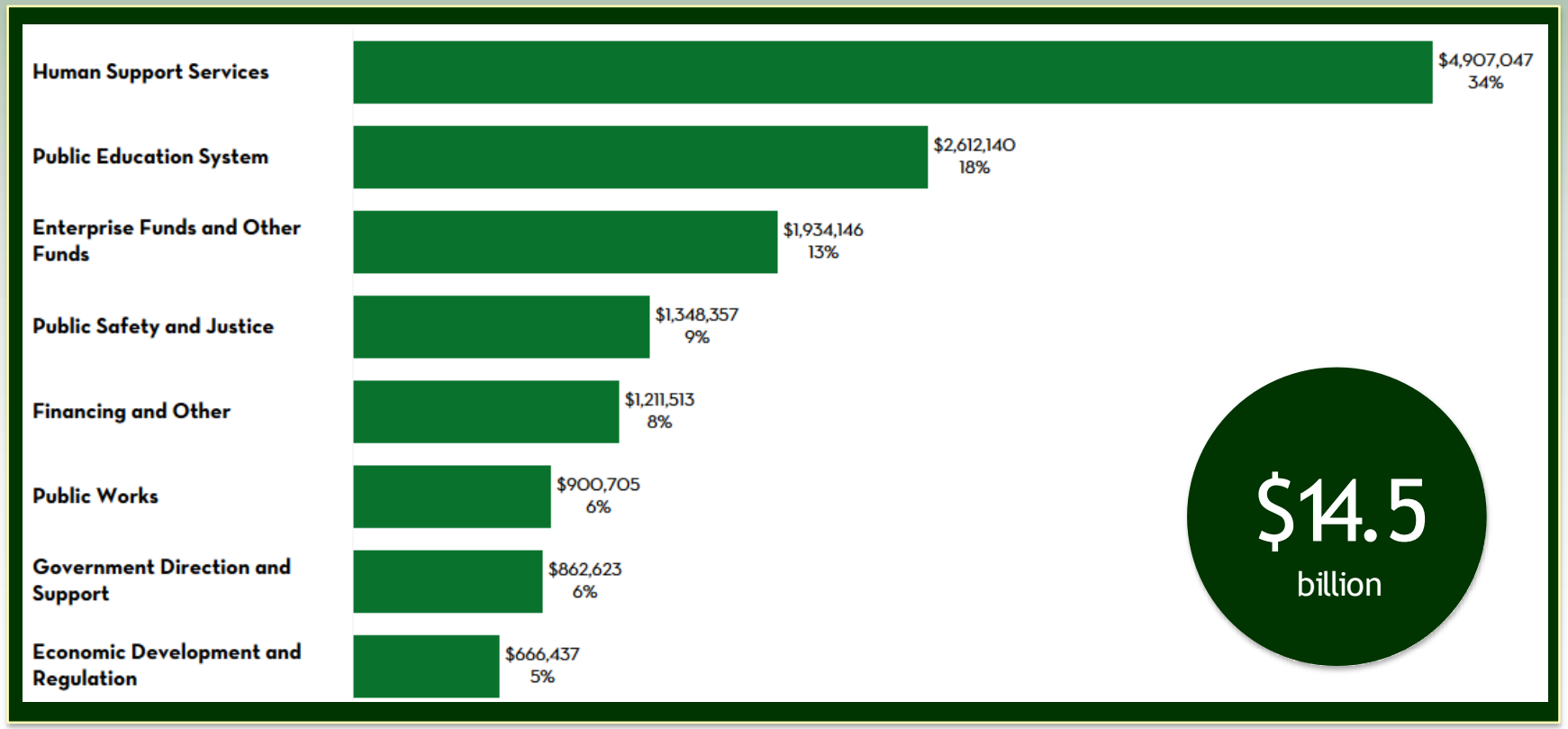
Sources of Gross Fund



*Dollars in thousands

Total Budget: Uses

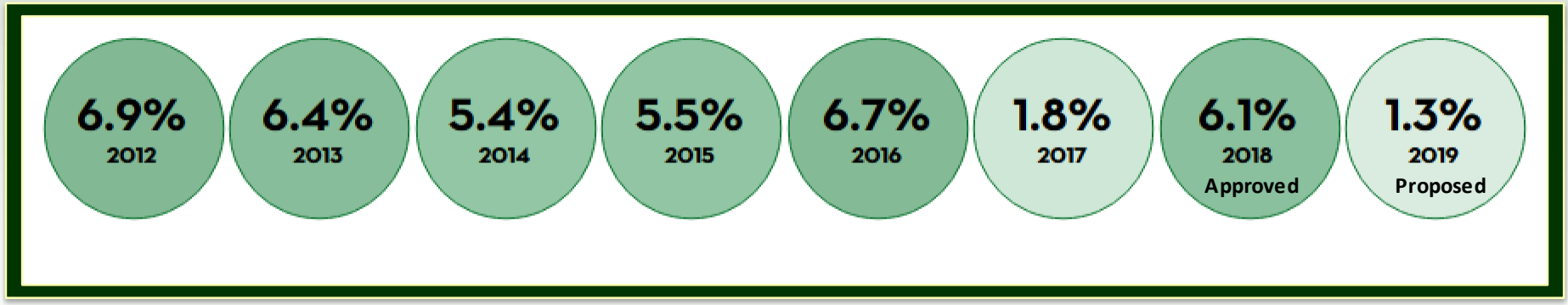
Gross Funds Expenditure Budget



*Dollars in thousands

Budget Growth (Local Funds)

Year-Over-Year Percent Change



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Building DHCF's FY19 Budget

FY 2018 Budget $713,077,581

FY 2019 Agency Request

Net Effect of Several Changes

-Provider Payment Increases $40,795,179
-Restructure to Create DCAS Management Administration $25,189,683
-Increases to Contracts and Administrative Costs $8,624,355
-Increases to Personal Services Costs $1,709,321
-FY 2019 COLA $777,731
-Removal of One-Time Costs $600,000

$76.5

FY 2019 Mayor's Adjustments

Enhancements

-Physician Supplemental Payment for Hospital Physician Services in Wards 7 and 8 $1,350,000
-Cost Allocation Plan Changes Supporting 10 FTEs, Audits, & Other Admin Costs $840,002

$2.2M

Reductions

-DSH for United Medical Center $1,369,336
-PACE Enrollment Starting in 4th Quarter $328,190
-Medicaid Managed Care Organization (MCO) Rate Savings $4,500,000
-Various Contracts Not Yet Implemented $2,302,475

($8.5M)

($6.3M)

FY 2019 Local Proposed Budget

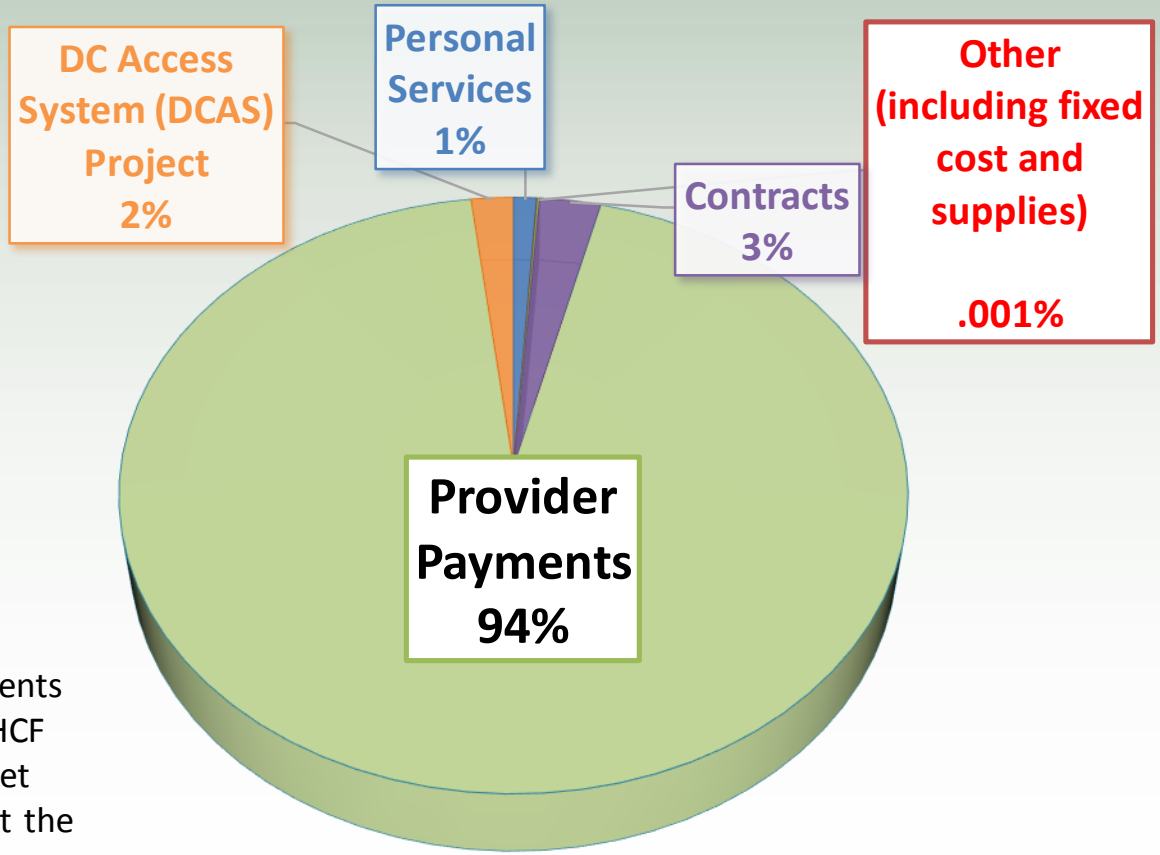
$783,263,852

DHCF Operating Budget By Spending Category

Spending Category	FY2018 Budget	FY2019 Proposed	% Change	FY18 FTE's	FY19 Proposed FTE's	Explanations
Personnel Services	29,371,074	33,879,782	15%	264	282	Net Increase of 18 FTE's to support the Ombudsman's office, LTC Oversight, Quality Oversight, Policy and Research staff, DCAS central support and shift from contract staff to FTE's
Fixed Cost	702,910	1,156,788	65%	-	-	In FY19, expansion of space at 441 4th St. NW
Supplies, Other Services and Equipment	3,290,571	3,394,929	3%	-	-	Increase mainly in Other services to include maintenance on additional copiers and cost associated with the expansion of space at 441 4th Street
Contracts	89,234,543	90,502,026	1%	-	-	
Provider Payments	3,069,715,272	3,099,189,185	1%	-	-	
DC Access System (DCAS) Project	-	62,519,908	100%	-	69	New eligibility system to replace ACEDs. DCAS was transferred from DHS to DHCF.
	3,192,314,370	3,290,642,619		264	351	

Structure of DHCF's Proposed FY2019 Budget

$3,290,642,619



Historically, provider payments represented 96% of the DHCF budget. The FY 2019 budget includes funding to support the new Eligibility Determination system, DCAS.

DHCF's FY2019 Proposed Strategies And Local Savings

$1.4 mil	**DSH Payments:** With the closure of the Obstetrics Department, United Medical Center is no longer eligible for DSH payments
$0.3 mil	**PACE:** Enrollment will begin in 4th quarter – initial budget estimate based on enrollments beginning in the 2nd quarter
$4.5 mil	**Medicaid MCO Rates:** Rates for the Medicaid Managed Care Organizations will drop by 4% from FY 2018 levels
$2.3 mil	**Contracts:** Reductions to contracts not yet implemented across the agency
$8.5 million	

DHCF FY2019 Enhancement Request to Expand Health Care in Wards 7 & 8

Cost: $4.5 million (Local Impact: $1.4 mil)

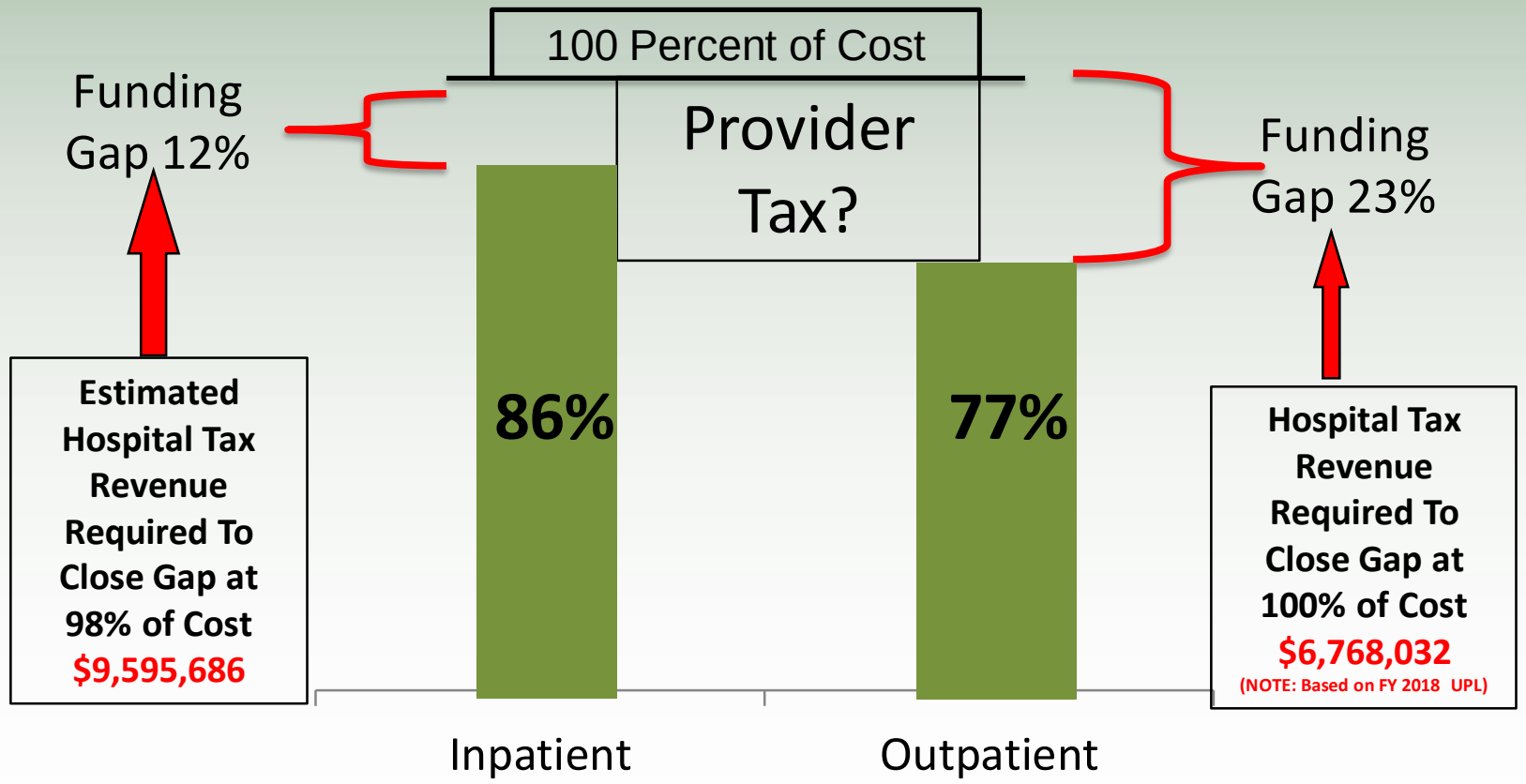
Physicians Supplemental Payment: The supplemental payment will provide a one-year payment issued to physician group practices enrolled in DC fee-for-service Medicaid that have agreed to provide inpatient/hospitalist, emergency department and intensive care physician services in Wards 7 and 8.

Budget Request For Medicaid Mandatory Services

Medicaid Mandatory Service	FY17 Expenditures*	FY18 Budgeted Amount*	FY19 Budget Request*
Inpatient Hospital	250.76	239.62	219.23
Nursing Facilities	251.39	275.48	291.60
Physician Services	34.49	39.79	30.72
Outpatient Hospital, Supplemental & Emergency	48.93	61.81	35.11
Durable Medical Equip (including prosthetics, orthotics, and supplies)	24.44	24.78	27.29
Non-Emergency Transportation	27.12	30.08	29.33
Federally Qualified Health Centers	36.20	54.14	55.91
Lab & X-Ray	16.60	26.24	17.96

* In Millions

Funding Level For Medicaid Inpatient And Outpatient Care In Mayor's Proposed Budget



Source: Mayor Muriel Bower's FY2019 proposed budget

Budget Request For Medicaid Optional Services

Medicaid Optional Services	FY17 Expenditures*	FY18 Budgeted Amount*	FY19 Budget Request*
Managed Care Services	1,165.32	1,293.68	1,218.31
DD Waiver (all FY 2017-19includes intra-district funds)	222.71	208.31	226.17
Personal Care Aide	206.96	196.53	224.39
EPD Waiver	68.67	48.78	86.16
Pharmacy (net of rebates)	29.24	62.43	23.06
Mental Health (includes PRTFs & DBH intra-district for MHRS)	88.71	86.19	106.52
Day Treatment / Adult Day Health	4.88	5.95	9.22
Home Health	7.12	16.01	16.21

* In Millions

MCO Rates, Expiration of Hospital Provider Taxes, And Community Long-Term Care Drive Changes

Provider Payment FY 2018 To FY 2019 Comparison (Total Computable)

Medicaid Provider Payments	• **Net decrease of $7 million in FY19** • Primarily, net effect of rate reductions to DC Healthy Families Program (MCO) and Expiration of Hospital Provider Taxes, and increases to EPD Waiver and PCA
Public Provider Payments	• **Net increase of $19 million in FY19** • Right-sizing of budget estimates for DCPS and OSSE • Budgeted for St. Elizabeth DSH after omission in FY18
Alliance Provider Payments	• **Net increase of $12.5 million** • Largely driven by 11.8% rate increase

DHCF Capital Projects In Six-Year Plan

Upgrade to Case Management System ($5.4M)

- **Purpose:** The system will support the District's No Wrong Door Initiative. DHCF continues to work with Sister agencies to ensure effective implementation of the various systems across agencies are not disjointed. The Case Management system will replace DHCF's current case management system (Case Net), replace DDS' current operating system, and create a new case management system for DCOA. Additionally, in December 2016, Congress enacted the 21st Century Cures Act. Section 12006 requires states to implement electronic visit verification (EVV) for Medicaid-financed Personal Care Services. The additional funding in FY19 will support the cost of the build of the EVV

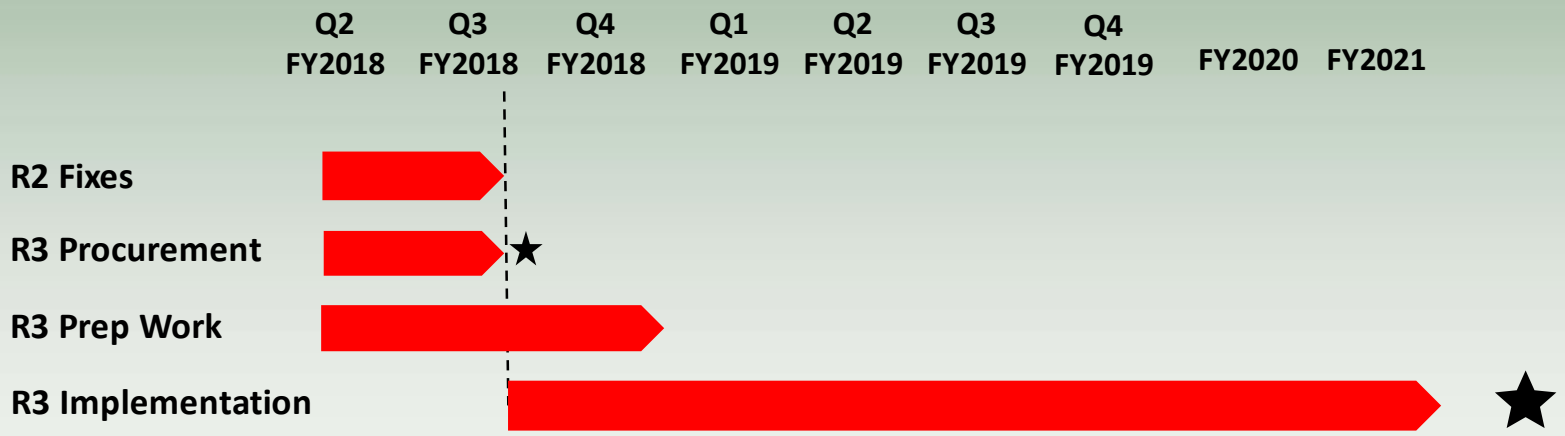
Medicaid Management Information System ($61.8M)

- **Purpose: T**he DC Medicaid Management Information System (MMIS) is the system that DHCF uses to process Medicaid claims, is required to be upgraded and certified every five years. In 2014, CMS issued guidance requiring States to develop a modular MMIS. DHCF has conformed to these requirements and is developing the new system as separate components in three phases: (1) Provider Data Management (2) Case Management; and (3) the Core system and support the cost of the IV&V vendor

D.C. Access System ($290.5M)

- **Purpose**: DCAS is an umbrella eligibility and enrollment system for Health and Human Services to provide access to cross agency automated databases for case data such as demographics, beneficiary data, and benefit issuance; which will allow new case information data to be added. This system will also determine Medicaid eligibility. In FY2019, DHCF is the lead agency responsible for the DDI and Operations of the new system. However, the project continue to be a collaborative effort between DHS, HBX and DHCF to ensure that all federal requirements are met.

DHCF Is Posed To Implement Release 3 – The Last Phase Of The DCAS Project



R3 Projected Spending					
	FY18 Total Cost	FY19 Total Cost	FY20 Total Cost	FY21 Total Cost	Total
Federal	$32,402,799	$47,894,070	$69,738,248	$46,492,165	$196,527,282
Local	$4,742,847	$46,640,168	$23,698,690	$15,799,127	$92,880.832
Total	$37,145,646	94,534,238	$93,426,938	$62,291,292	$287,398,114

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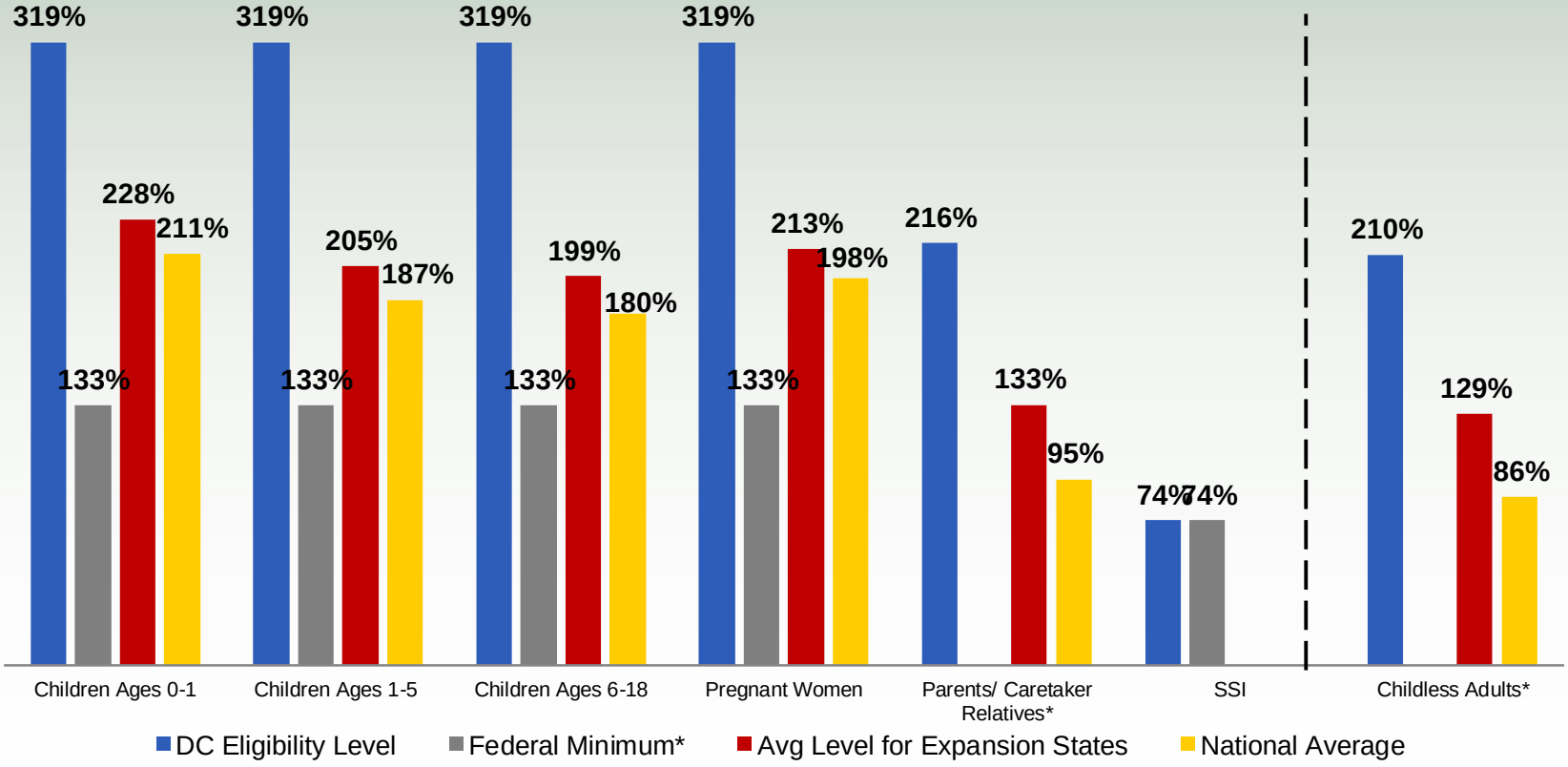
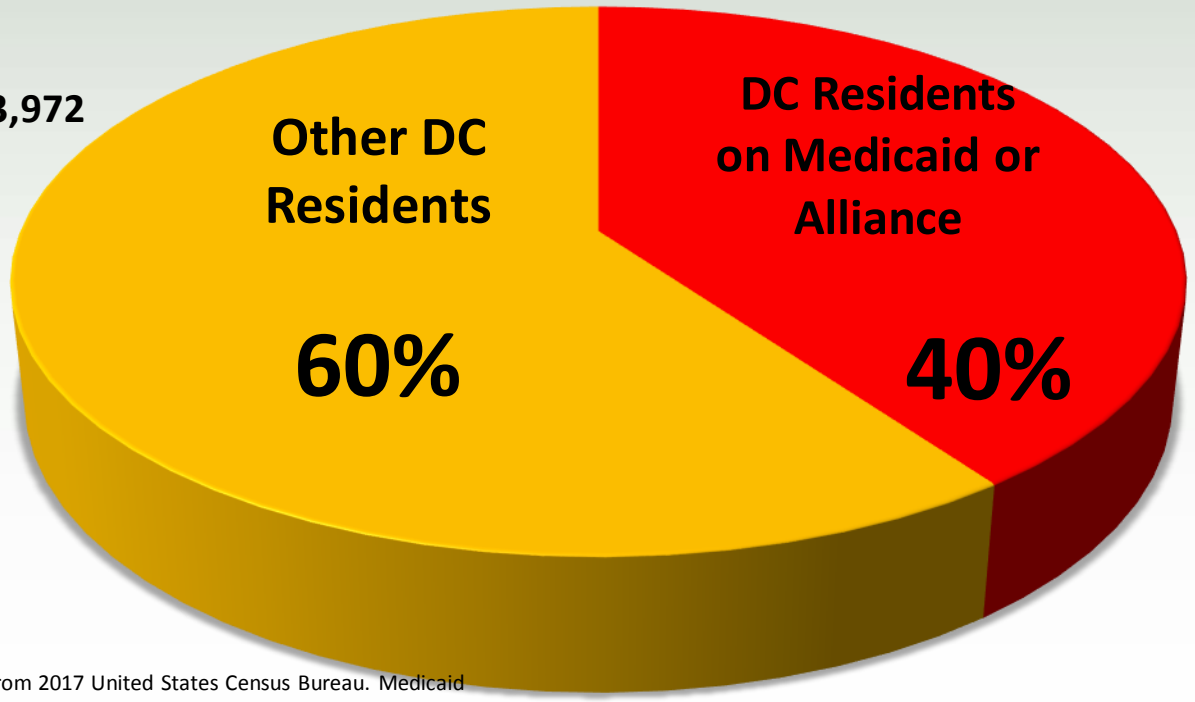
The District's Eligibility Levels Exceed Federal Requirements And Statewide Averages



Source: Centers for Medicare and Medicaid Services State Medicaid and CHIP Income Eligibility Standards, updated June 2016.

Four In 10 District Residents Rely On Medicaid Or Alliance For Health Care Coverage

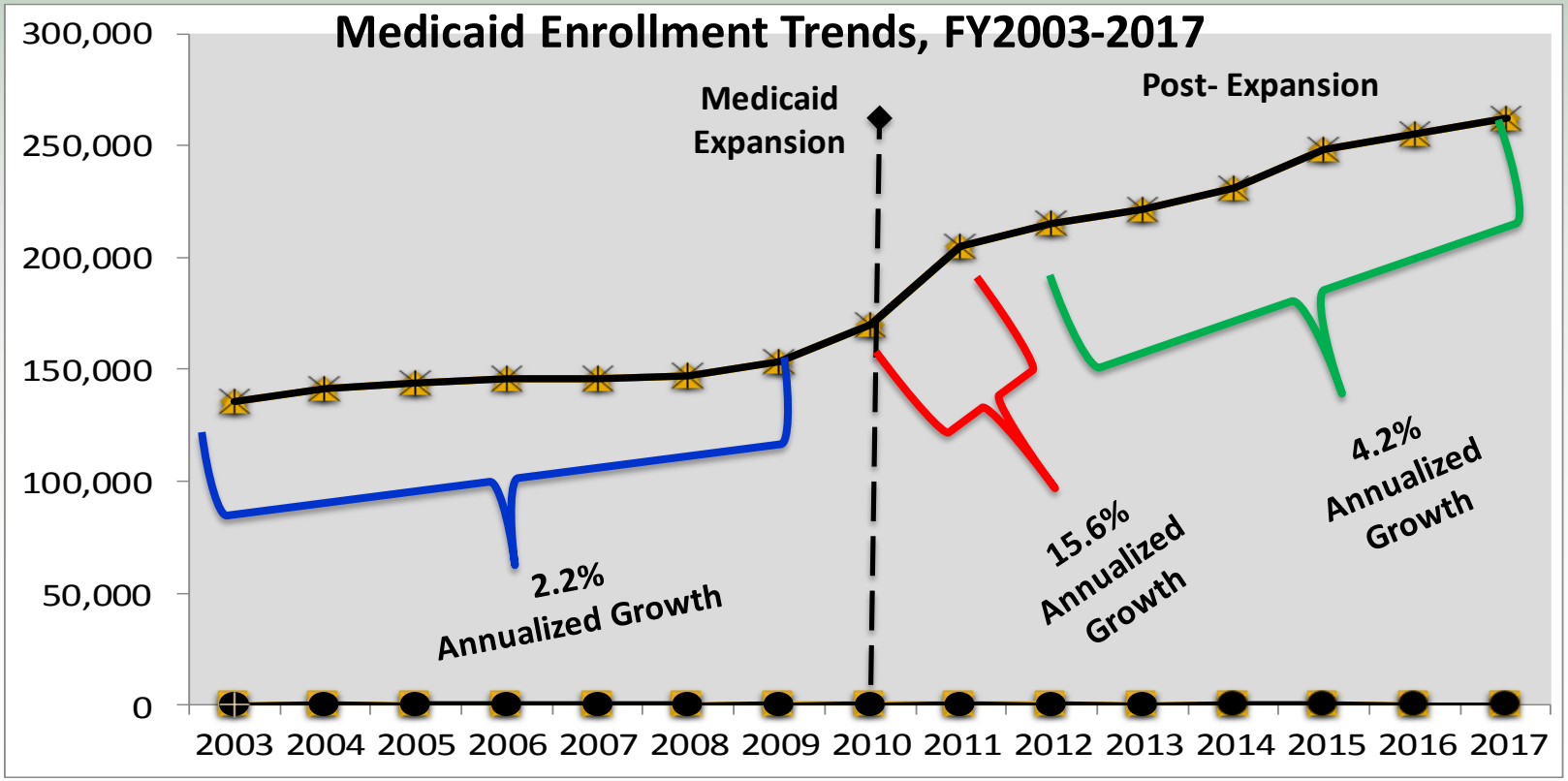
*Total Residents 693,972



Source: District population estimate from 2017 United States Census Bureau. Medicaid and Alliance data reported from DHCF's Medicaid Management Information System (MMIS).

Note: These data excludes some District residents who are not United States Citizens and thus the percent of residents on publicly funded health care may be slightly overstated..

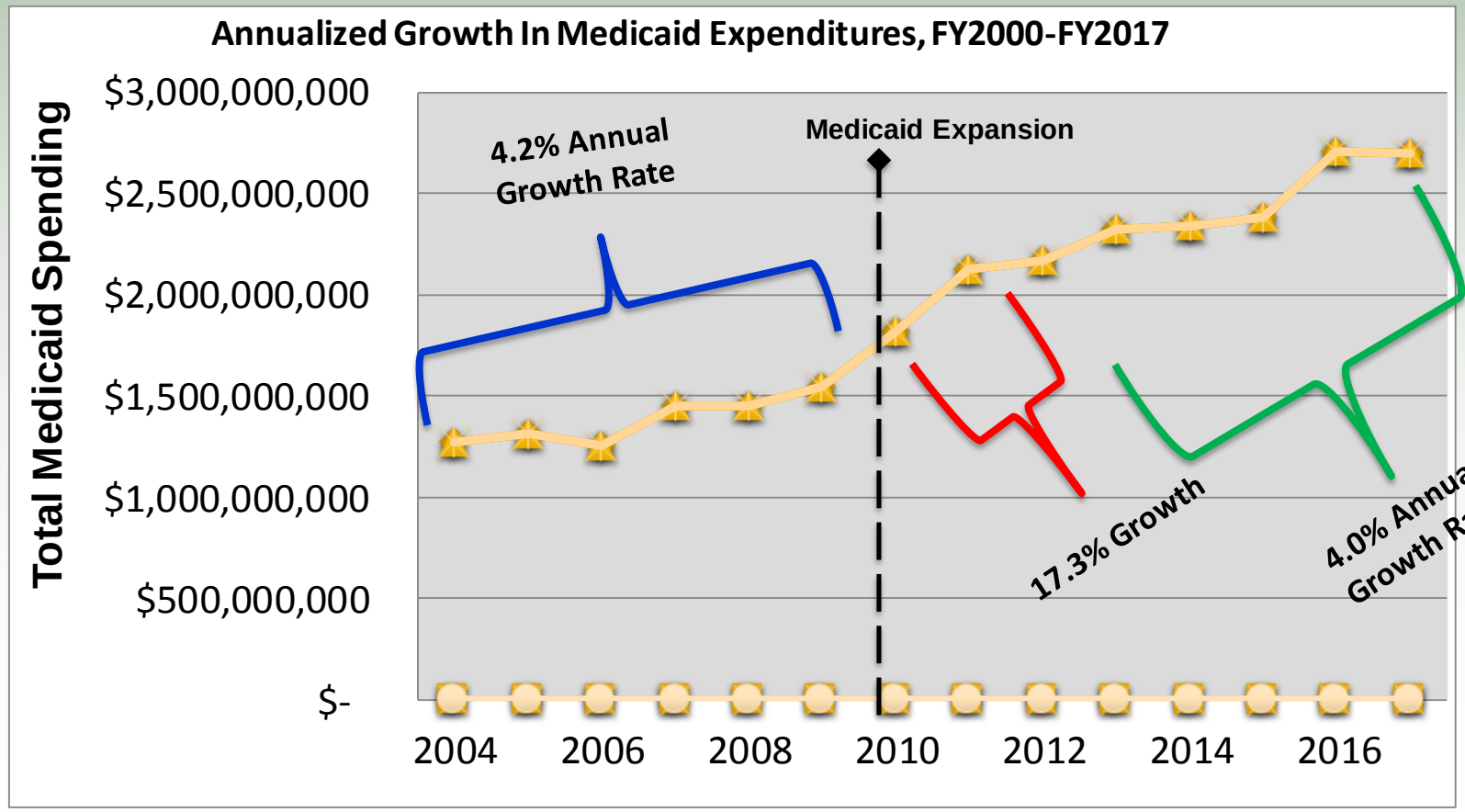
Since ACA Implementation, Medicaid Enrollment Growth Is Now More Than Double Pre-ACA Levels



Notes: Excludes ineligible individuals (individuals who failed to recertify due to lack of follow-up, moving out of the District, excess income, or passed away), and those in the Alliance and Immigrant Children programs.

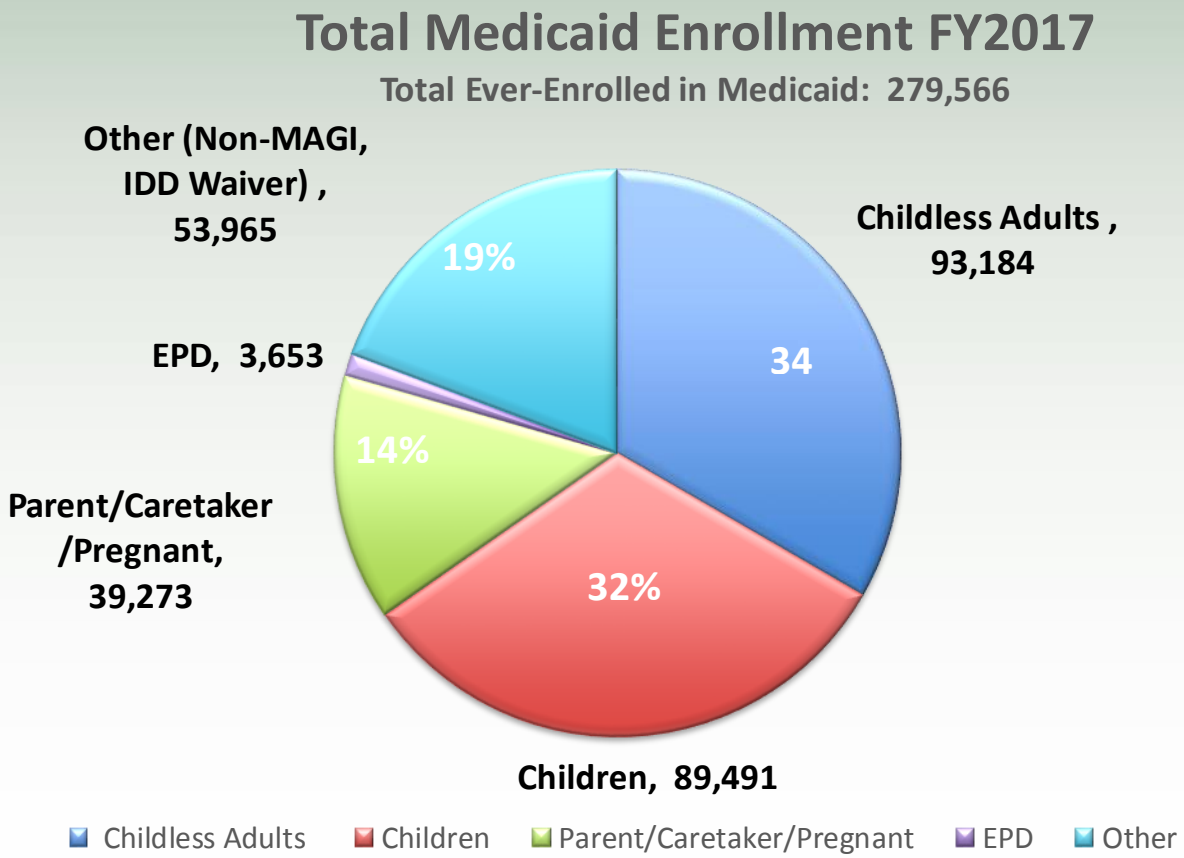
Source: Data for 2000-2009 data was extracted by Xerox from tape back-ups in January, 2010. Data from 2010-present are from enrollment reports.

Medicaid Cost Trends Track Enrollment Growth Trends



Source: Spending totals extracted from Cognos by fiscal year (October, 1 through September, 30). Includes fee-for-service paid claims only, including adjustments to claims, and excludes claims with Alliance or Immigrant Children's group program code. Only includes claims adjudicated through MMIS; excludes expenditures paid outside of MMIS (e.g. pharmacy rebates, Medicare Premiums).

Childless Adults and Children Each Represent A Third of Medicaid Enrollees



Data Source: DC Medicaid Management Information System (MMIS) beneficiary data, extracted March 5, 2018.

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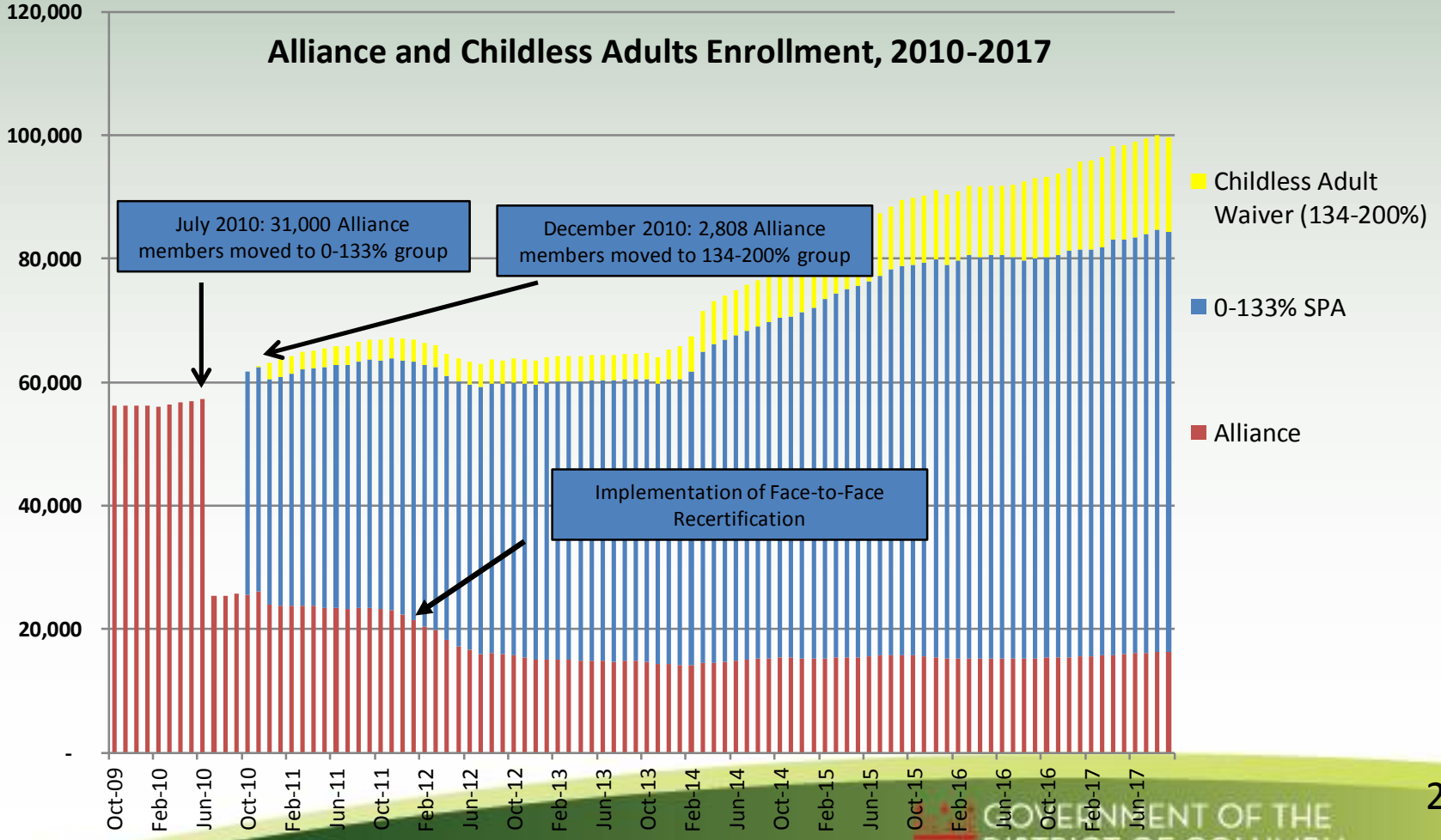
Enrollment Trends for Medicaid Childless Adults and Alliance Members Document The Shift From Alliance to Medicaid



Source: Excludes ineligible individuals – persons who failed to recertify due to lack of follow-up, moving out of the District, or had excess income, or passed away. Data are from enrollment. reports

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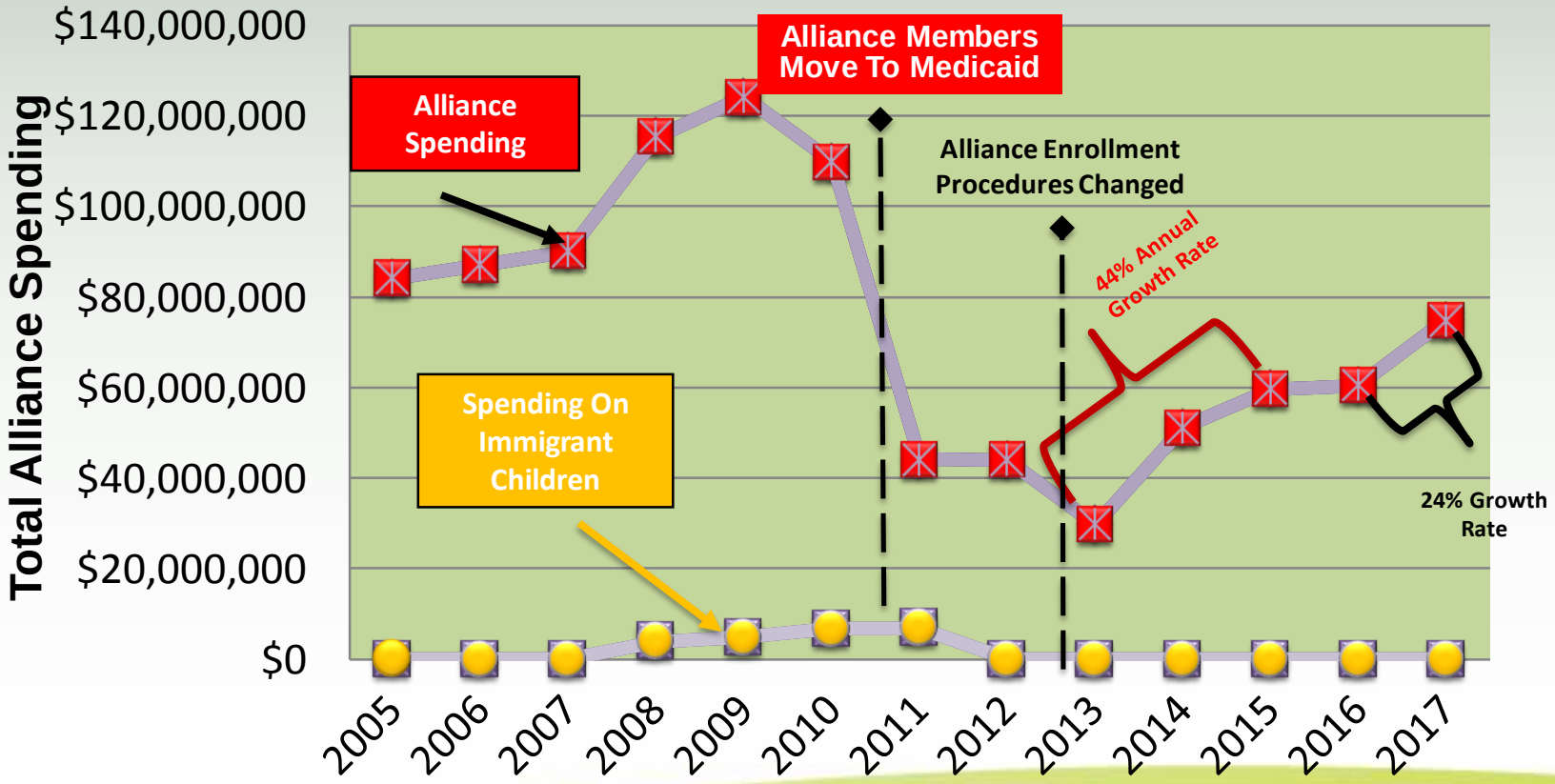
Alliance Costs Grew From 2016 to 2017, Driven in Part by Increases in Pharmacy and Outpatient Hospital Spending



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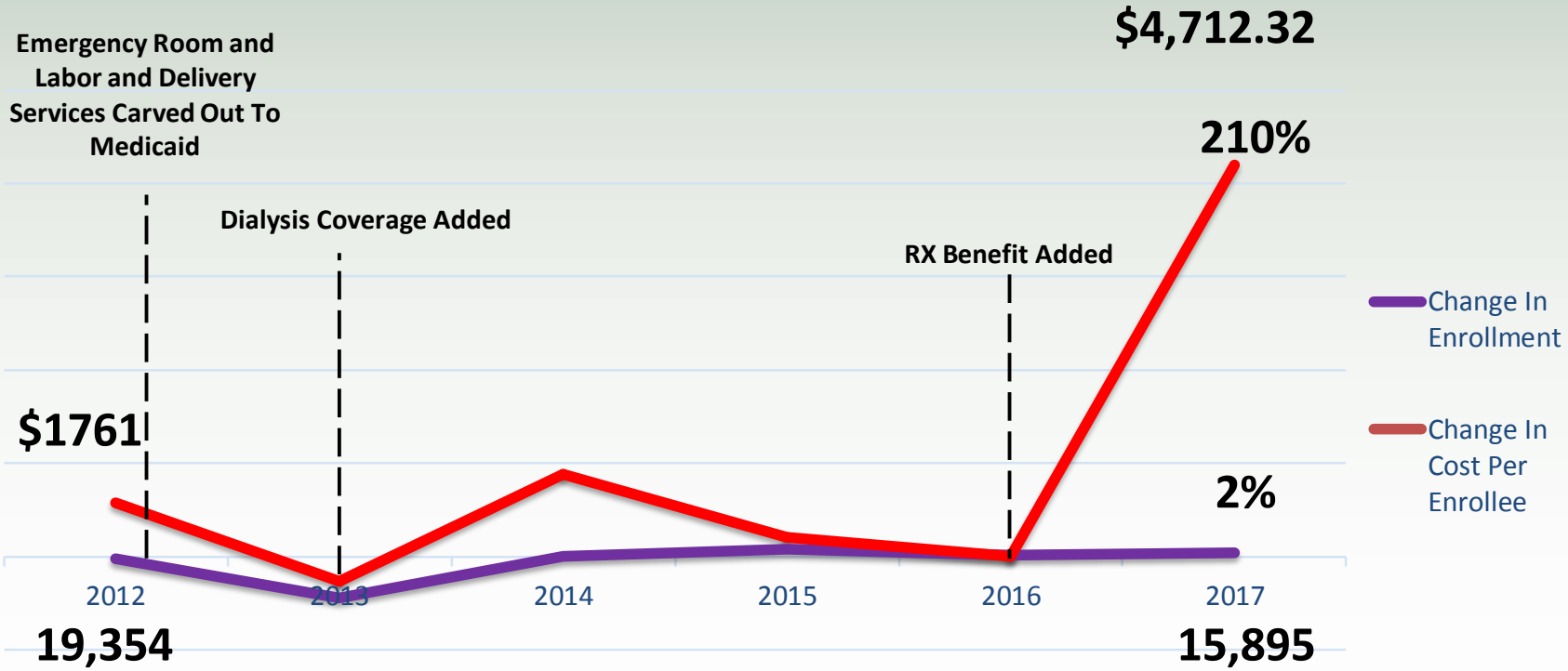
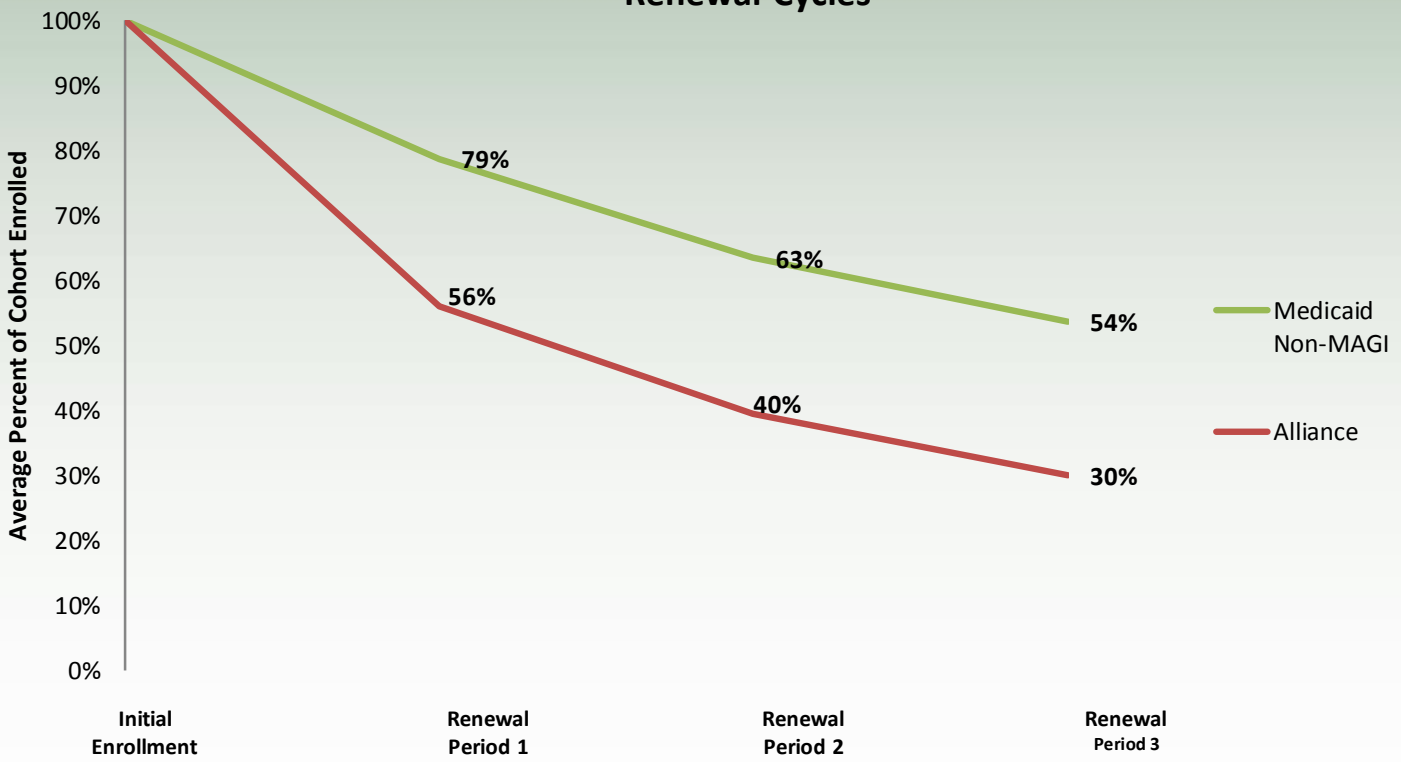
While Alliance Enrollment Growth Has Been Flat, The Cost Per-Enrollee Has Sharply Spiked

Year-Over-Year Percent Change In Alliance Enrollment And Cost-Per Enrollee



Adult Medicaid Beneficiaries Retain Coverage At A Higher Rate Than Alliance Beneficiaries

Average Coverage Retention Rates For Medicaid and Alliance Beneficiaries Over Three Renewal Cycles



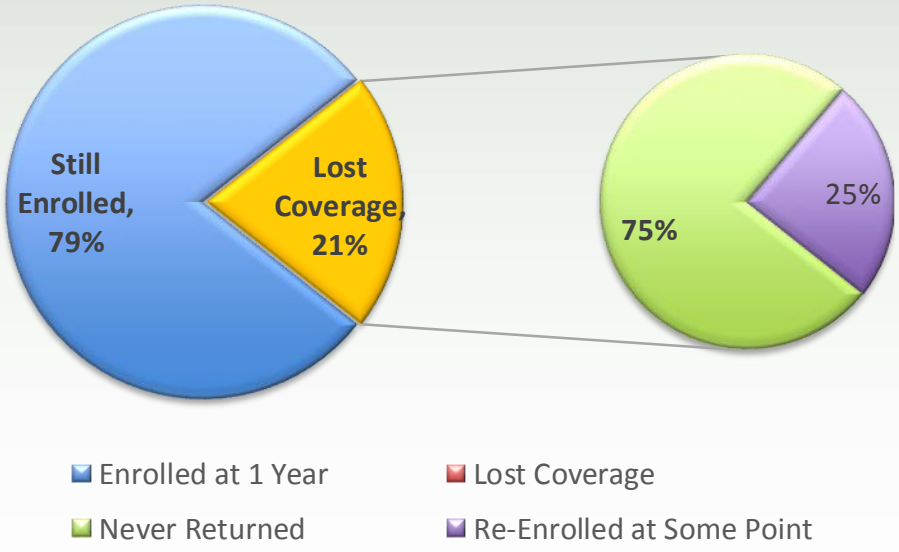
Source: 2012-2016 Enrollment data DC MMIS, analyzed by DHCF June 2017

Note: Percentage represents the average experience of 12 cohorts of Alliance and Medicaid beneficiaries. Beneficiaries were included in a cohort if they had an enrollment span that began in one of the 12 months between December 2012 and November 2013 and were not enrolled in the prior month. Beneficiaries who renewed coverage within 60 days of their enrollment span end date are recorded in MMIS as having continuous coverage and are therefore not included in this analysis. DHCF tracked beneficiary enrollment experience by reviewing enrollment status after the 1st, 2nd, and 3rd eligibility cycle after the initial coverage month to assess coverage retention (7 months, 13 months and 19 months for Alliance beneficiaries and 13 month, months, and 37 months for Medicaid beneficiaries). Medicaid cohorts exclude children, long-term care recipients, and MAGI recipients (who has deferred renewal during the study period).

Alliance Beneficiaries Were More Likely To Re-Enroll After Losing Coverage Than Medicaid Beneficiaries

Alliance and Medicaid Re-enrollment Patterns

Reenrollment Rates For Alliance Beneficiaries



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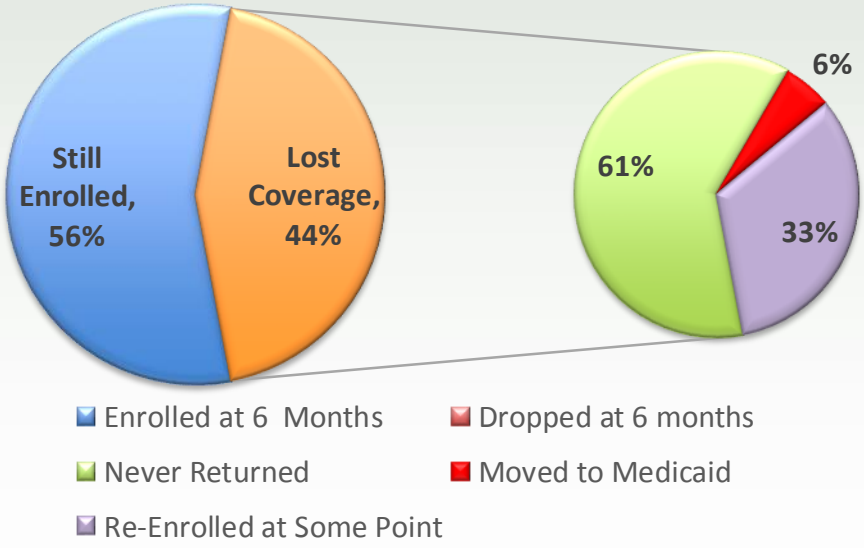

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DHCF Research Found An Independent And Adverse Enrollment Effect Of The Six-Month Face-to-Face Alliance Recertification Policy

Factors Influencing Alliance and Medicaid Beneficiary Disenrollment

Research Questions

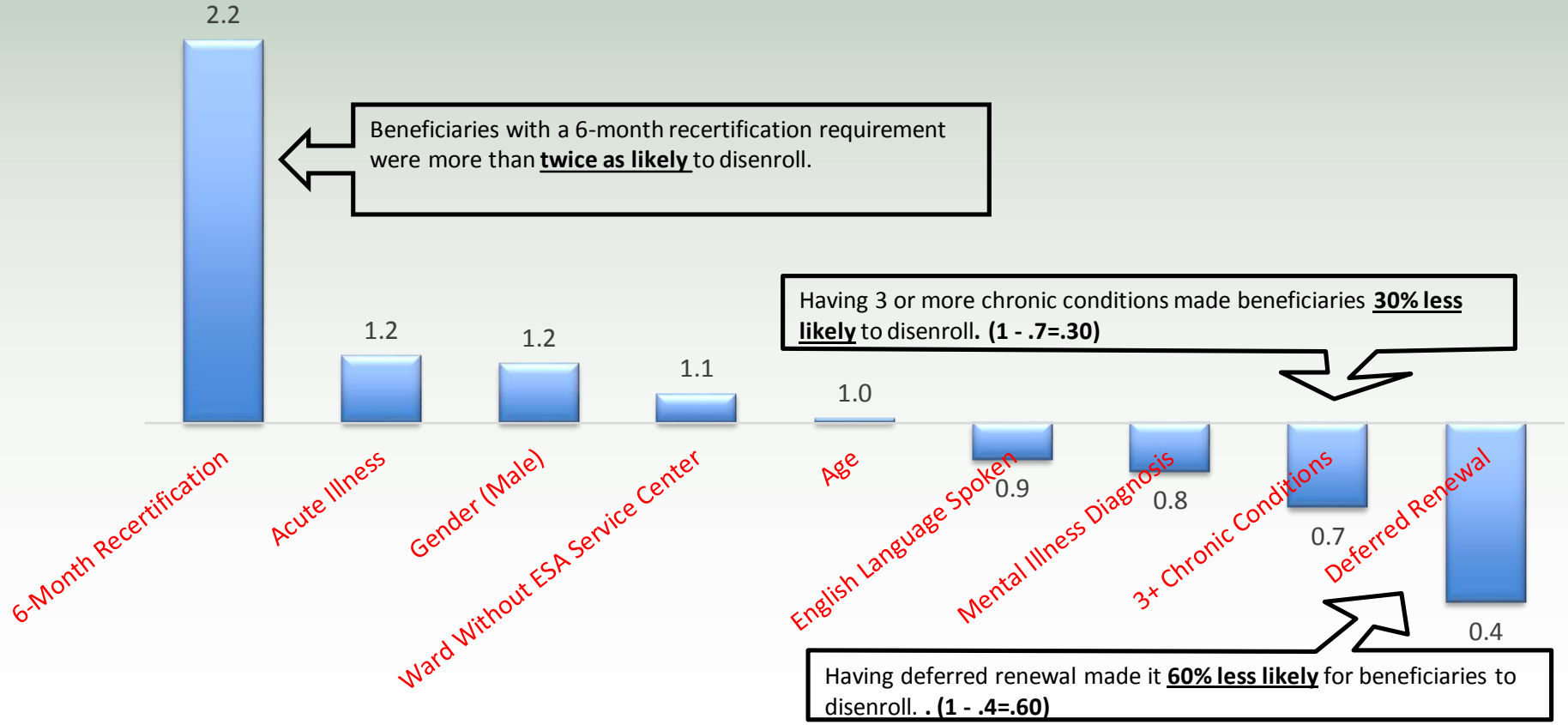
1. What is the effect of the six-month face-to-face recertification requirement on disenrollment among Alliance beneficiaries, after controlling for other factors?
2. For beneficiaries who disenrolled after their first enrollment span, was acute illness associated with their disenrollment?
   a) Alliance
   b) Medicaid

Preliminary Findings:

- Beneficiaries with a 6-month recertification requirement (Alliance beneficiaries) were more than twice as likely to disenroll.
- Beneficiaries with three or more chronic conditions were 30% less likely to disenroll; these effects were significant across all study populations.

*Note: Because DHCF does not collect data on reasons for beneficiary disenrollment, which could include loss of DC residency, inability to complete the enrollment process, or no longer having a need for services, it is difficult to determine whether the shorter tenure of Alliance beneficiaries was appropriate given beneficiary circumstances – DHCF is conducting additional research.

Factors Impacting The Likelihood Of Disenrollment For Alliance And Medicaid Beneficiaries



The Development of DCAS Is Organized In Three Separate Releases

Release 1

***BENEFIT PROGRAMS**:

Assisted Insurance:

MAGI Medicaid

QHP (Premium Tax Credits)

Unassisted Insurance:

SHOP

Individual Market

SOFTWARE PRODUCT:

HCR Caseworker Portal

HCR Citizen Portal

Release 2

***BENEFIT PROGRAMS**:

Food Benefits:

SNAP; ESNAP; TSNAP; DSNAP

Energy Assistance:

LIHEAP

Cash Benefits:

TANF; POWER; GC; IDA; RCA; Burial Assistance.

SOFTWARE PRODUCT:

CGISS Caseworker Portal

Release 3

***BENEFIT PROGRAMS**:

Medical:

Non-MAGI Medicaid

Alliance

Immigrant Children's Program

Family Services Programs:

Homeless Services Program Management, and other human service benefits

Economic Services Programs:

SNAP & TANF Enhancements

SOFTWARE PRODUCT:

CGISS Caseworker Portal

CGISS Citizen Portal

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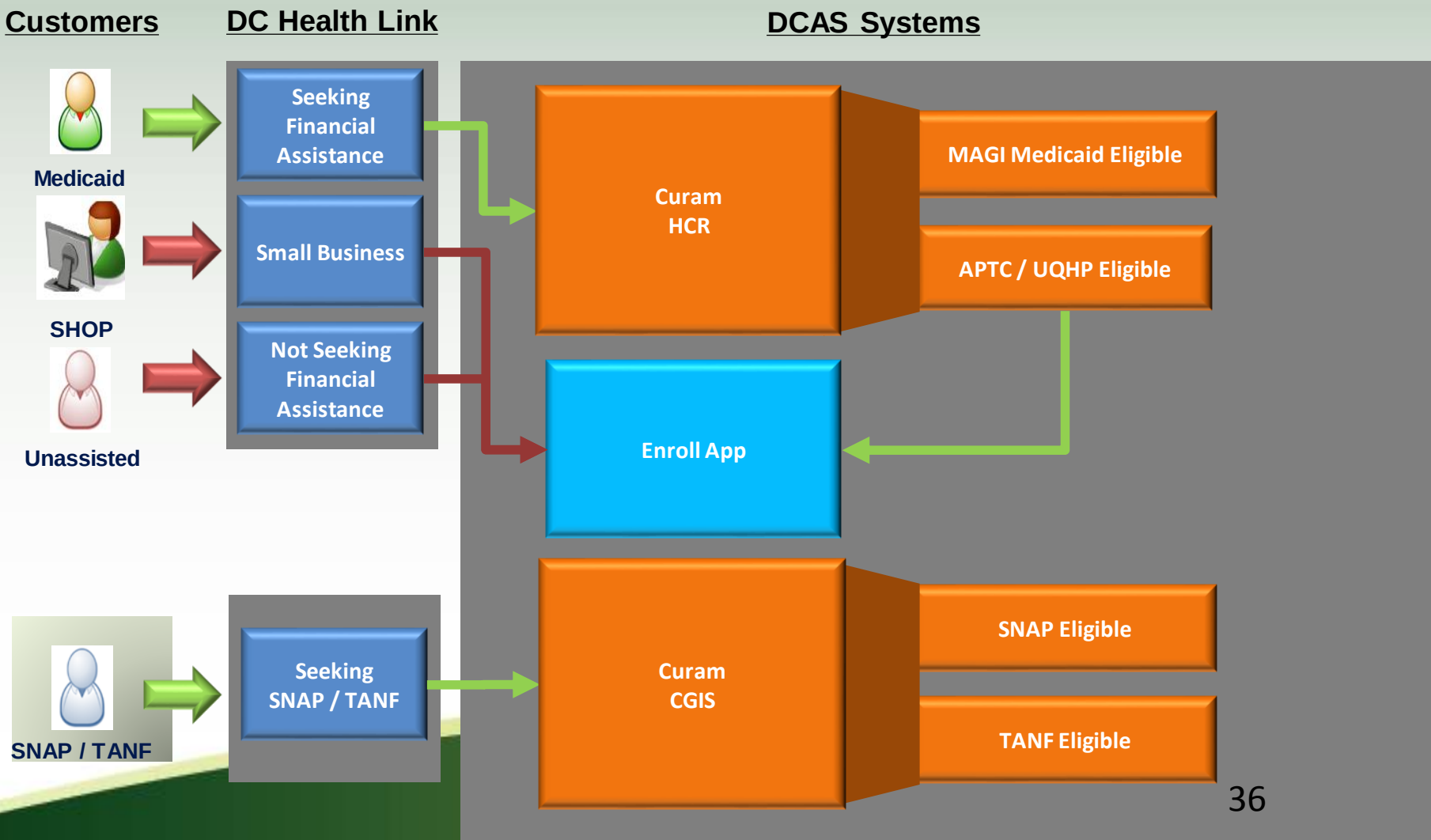
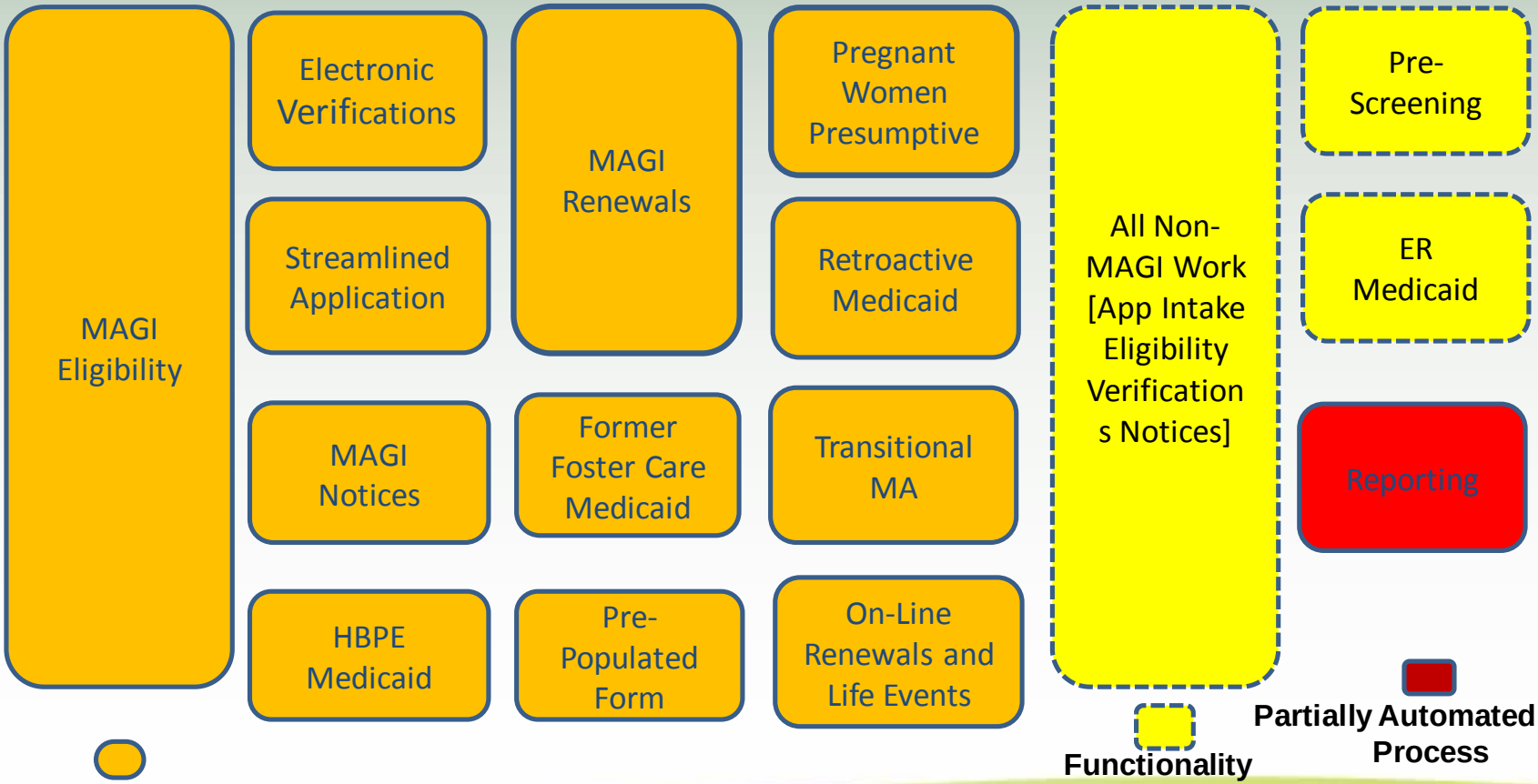
DCAS Is Designed To Assist Persons Seeking Publicly-Financed Health Care Insurance, Private Insurance With and Without Subsidies, And Public Assistance Benefits

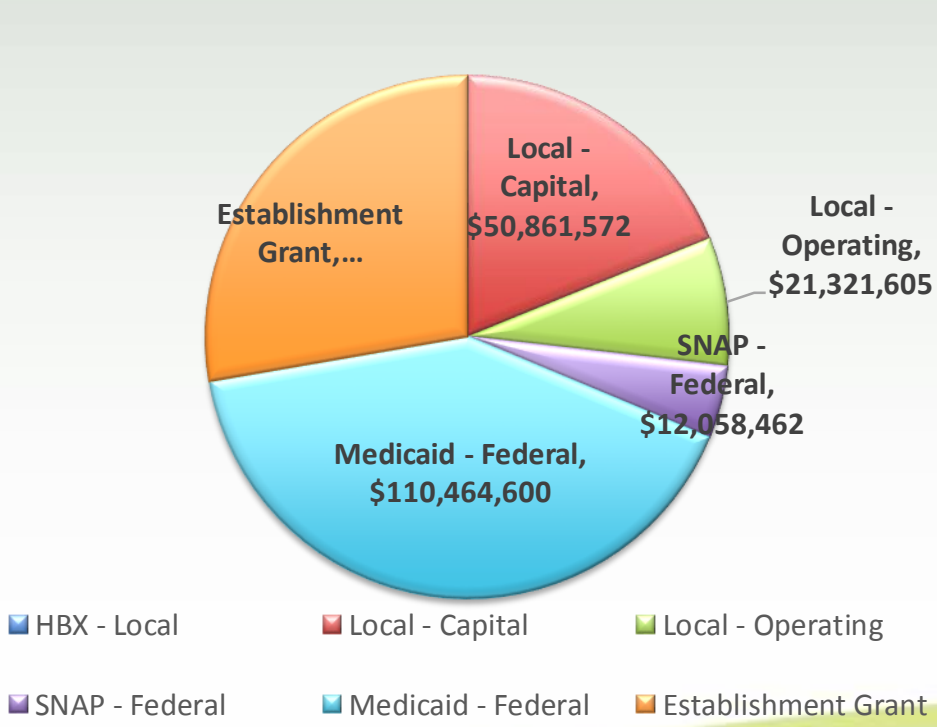


DCAS Release 1 Functionality Is Nearly Complete With the Final Phase Addressed in Release 3

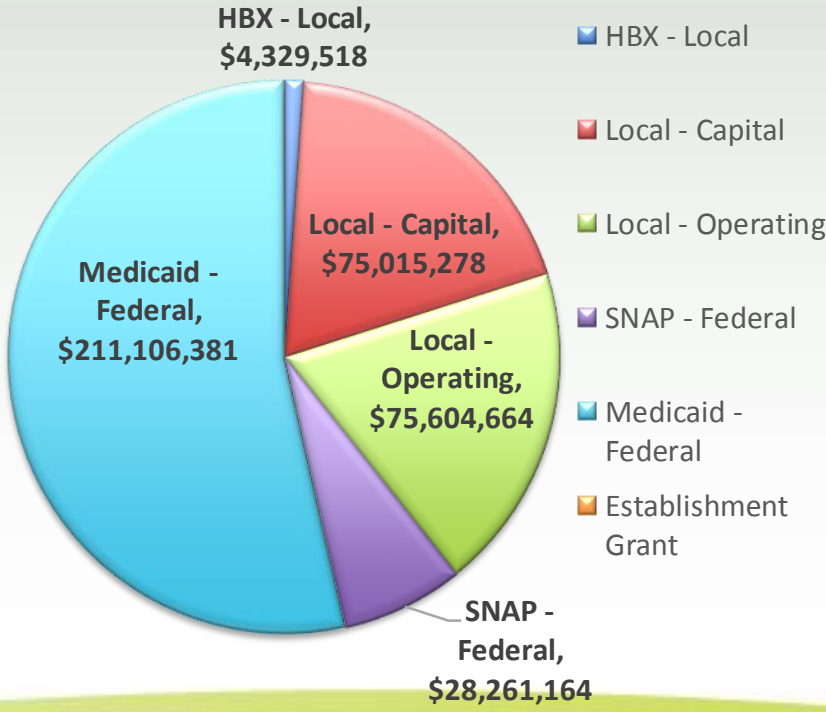


DCAS Spending: Total Past And Projected Funding

Past DCAS Spending (FY12 - FY17)
Total: $269,446,488



Projected DCAS Spending (FY18 - FY20)
Total: $394,317,005



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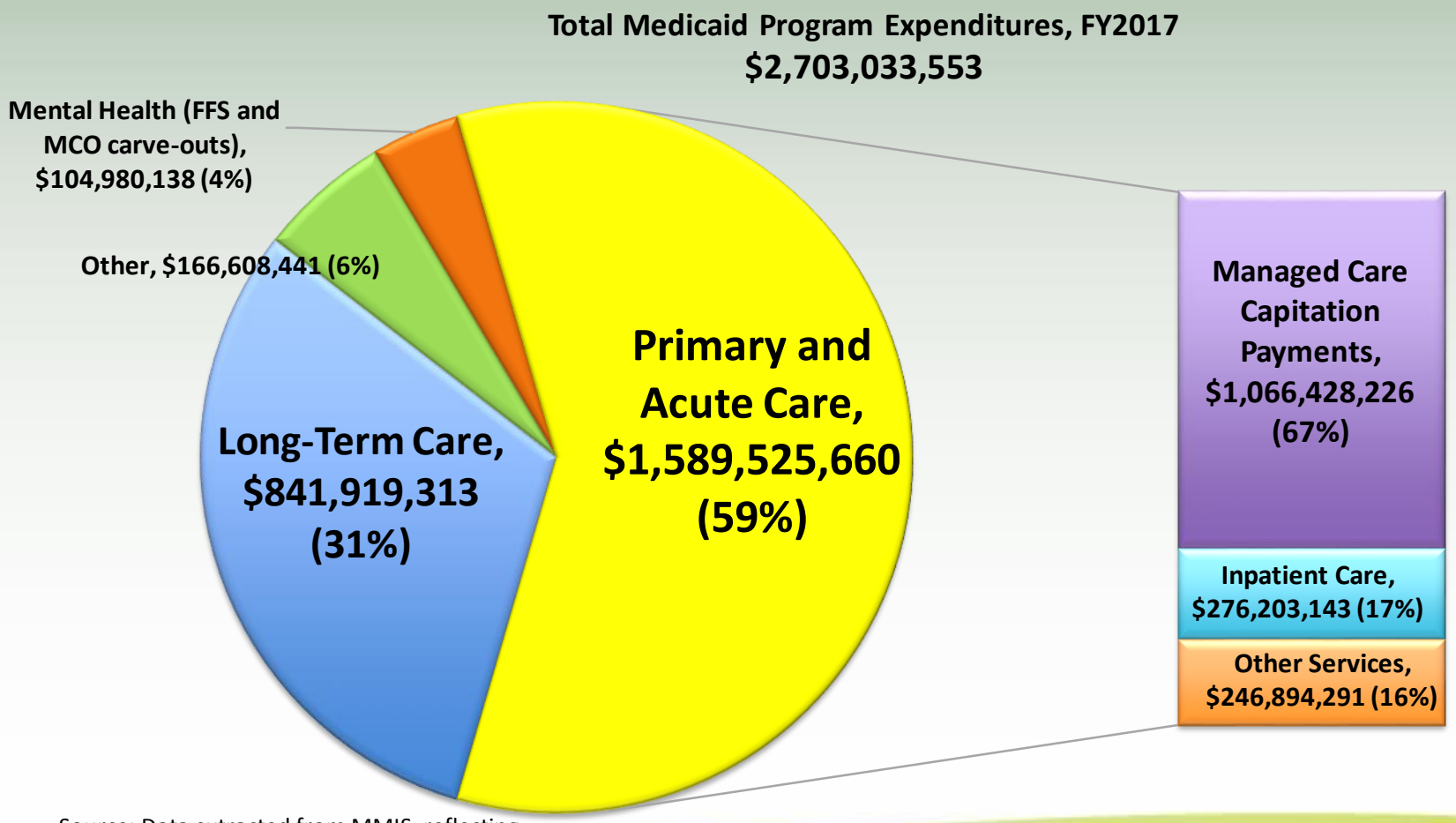
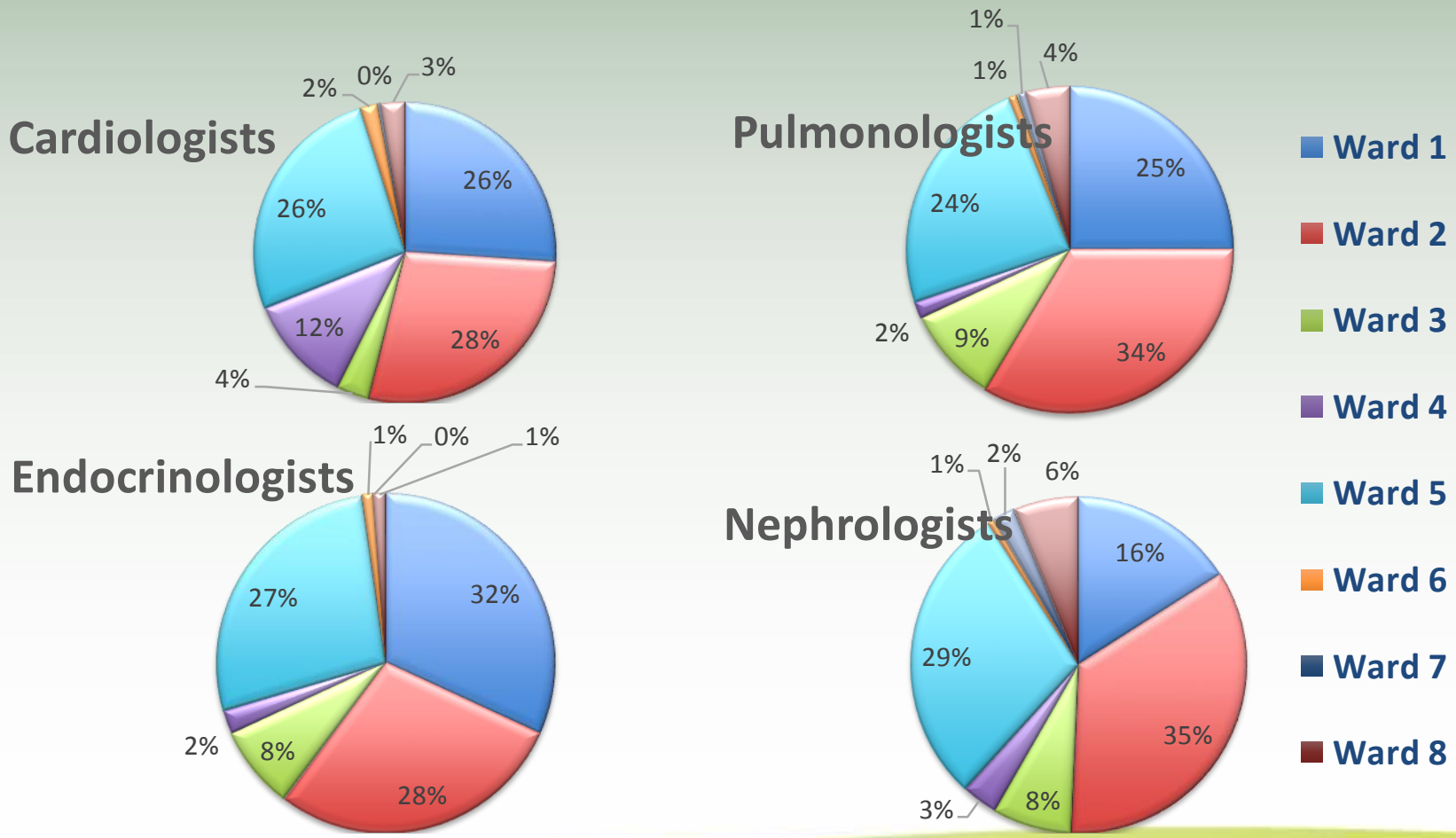
Acute and Primary Care Costs Drive Overall Medicaid Spending



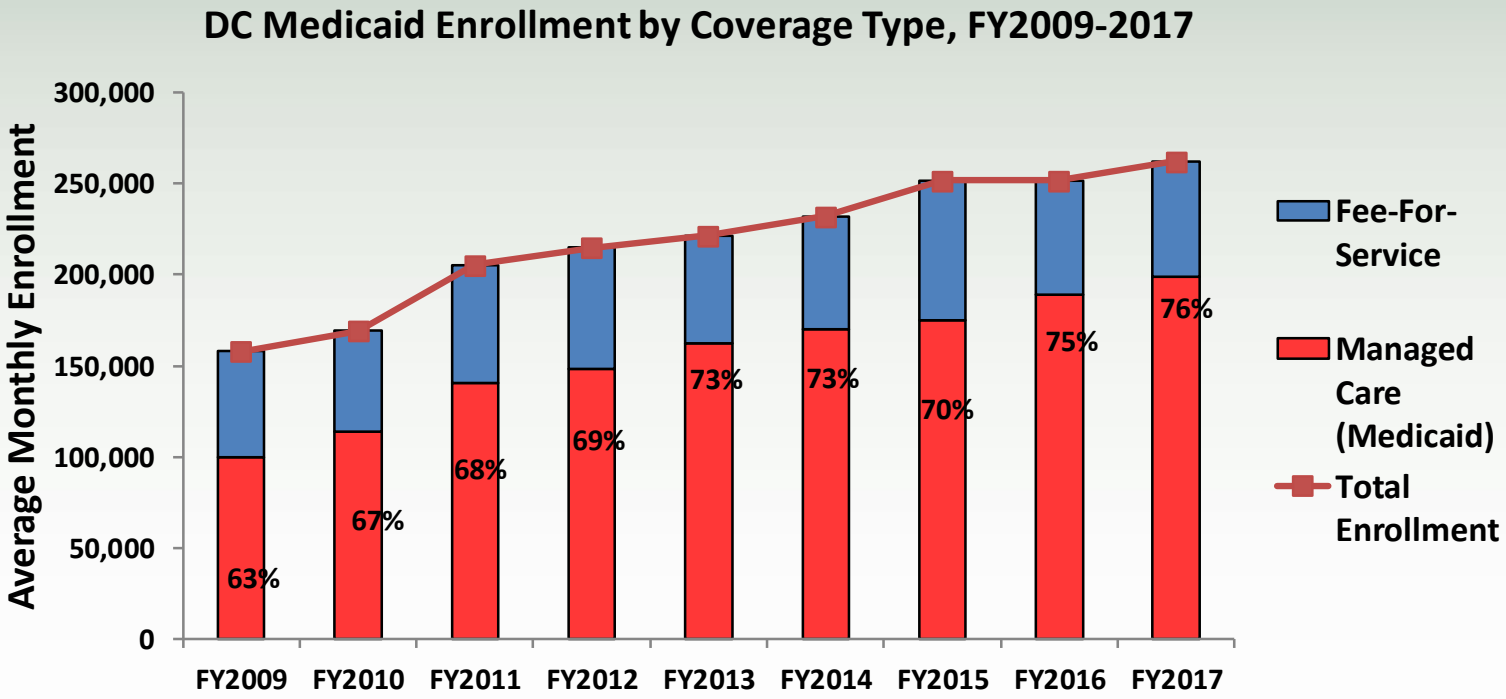
Source: Data extracted from MMIS, reflecting claims paid during FY2017

The Majority of Specialists Currently Serving Medicaid Beneficiaries Are Concentrated in Wards 1, 2 and 5



**Data on FFS providers extracted from DC MMIS on Mar 13, 2018. Data on MCO providers were provided by each participating MCO.

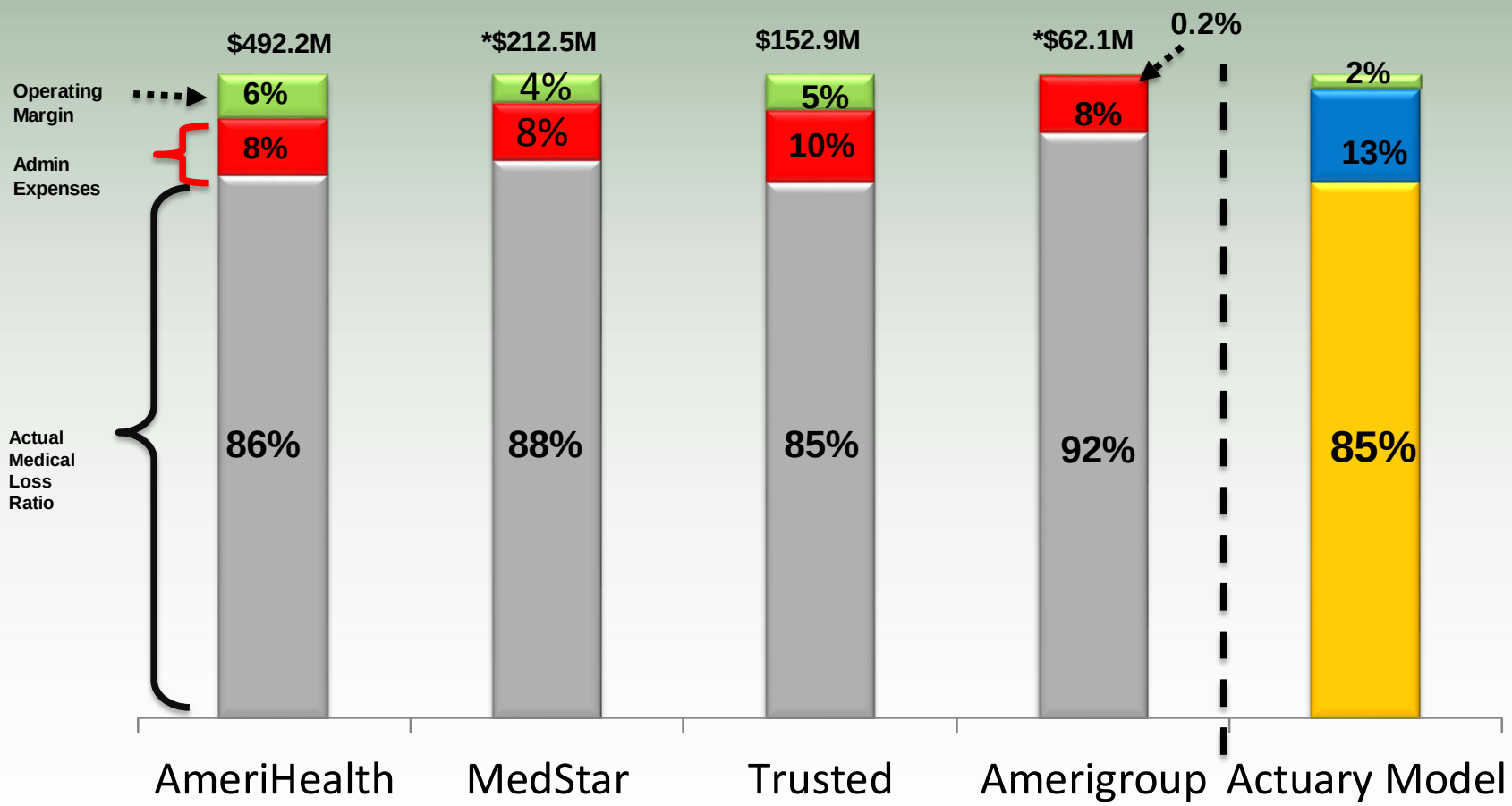
More Than Three-Fourths of Medicaid Enrollees Are In The Managed Care Program



Source: DHCF staff analysis of data extracted from the agency's Medicaid Management Information System

Full Risk MCOs Met Medical Spending Requirements

Actual MCO Revenue At Target Rate For January 2017 to December 2017*



Notes: *In 2017 DHCF awarded new contracts for the District MCOs for FY18. MedStar's financial results represent data from January 2017 through September 2017. Amerigroup's financial results represent data from October 2017 through December 2017. All other MCOs financial results are reported on an annual basis. AmeriHealth's MLR reported to DHCF on a reported basis for 2017. Per CMS new guidelines, DHCF will monitor and report on MLR using an incurred basis in future reports. MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings and self reported quarterly filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes.

Source: MCO Quarterly Statement filed by the health plans with the Department of Insurance, Securities, and Banking for the three full risk MCOs and self reported Quarterly statements for shared risk plan, HSCSN

DHCF Relies Upon Several Metrics To Quantitatively Assess The Efforts By The Health Plans To Coordinate Enrollee Care

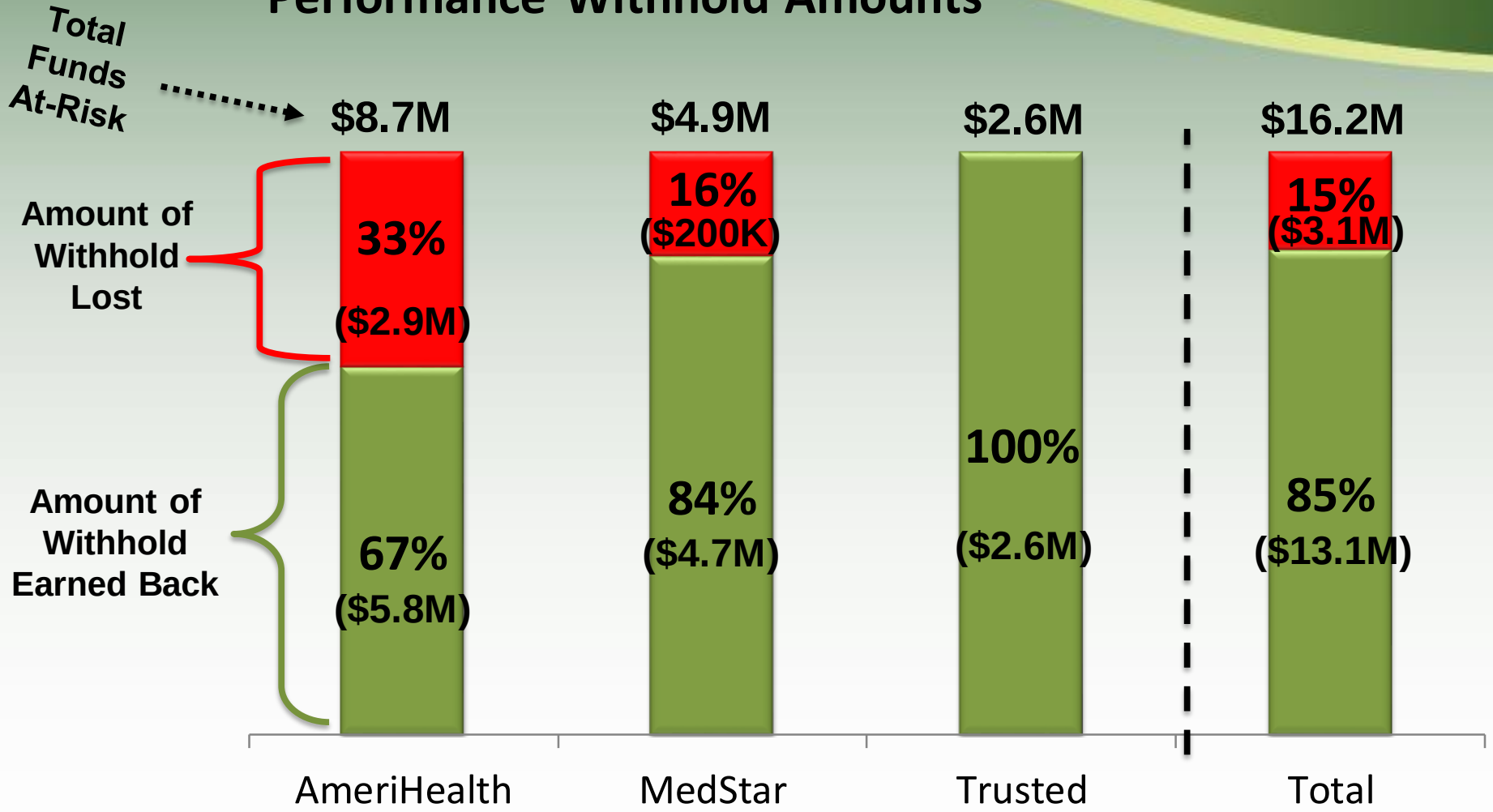
- DHCF is implementing new initiatives to achieve our goal of promoting high value in health care for Medicaid and Alliance beneficiaries
- Beginning on October 1, 2016, the District's three full-risk managed care plans were expected to increase their members' health care and improve outcomes per dollar spent through aggressive care coordination and health care management.
- DHCF is now monitoring the following performance indicators for each of the District's three health plans:
  - Emergency room utilization for non-emergency conditions
  - Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary and preventative care
  - Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days -- hospitalization

The Managed Care Plans Have Experienced Some Success In The First Year Of The Pay-For-Performance Program

	Performance Metrics		
Health Plans	Preventing Use Of Emergency Room For Non-Emergencies	Preventing Hospital Readmissions Within 30 Days Of Previous Admissions	Preventing Avoidable Hospital Admissions
	Did Health Plan Meet The Standard?		
AmeriHealth	Yes	Yes	*No
MedStar	Partially	Yes	Yes
Trusted	Yes	Yes	Yes

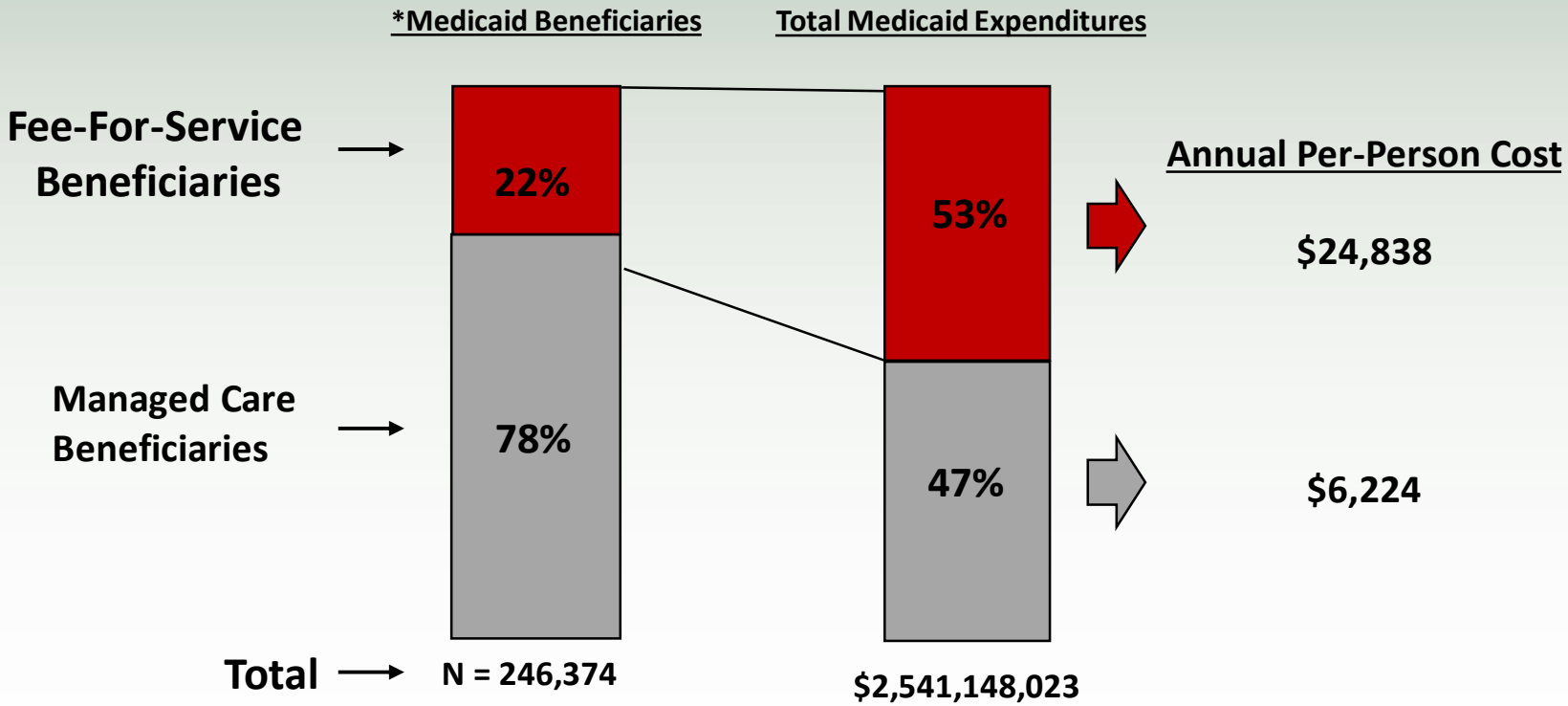
Note: *Calculations performed by Mercer Consulting using DHCF capitated payment data and MMIS claims. AmeriHealth's numbers are not final, pending the submission of claims that are presently under review.

The Health Plans Earned Back 85 Percent Of The Performance Withhold Amounts



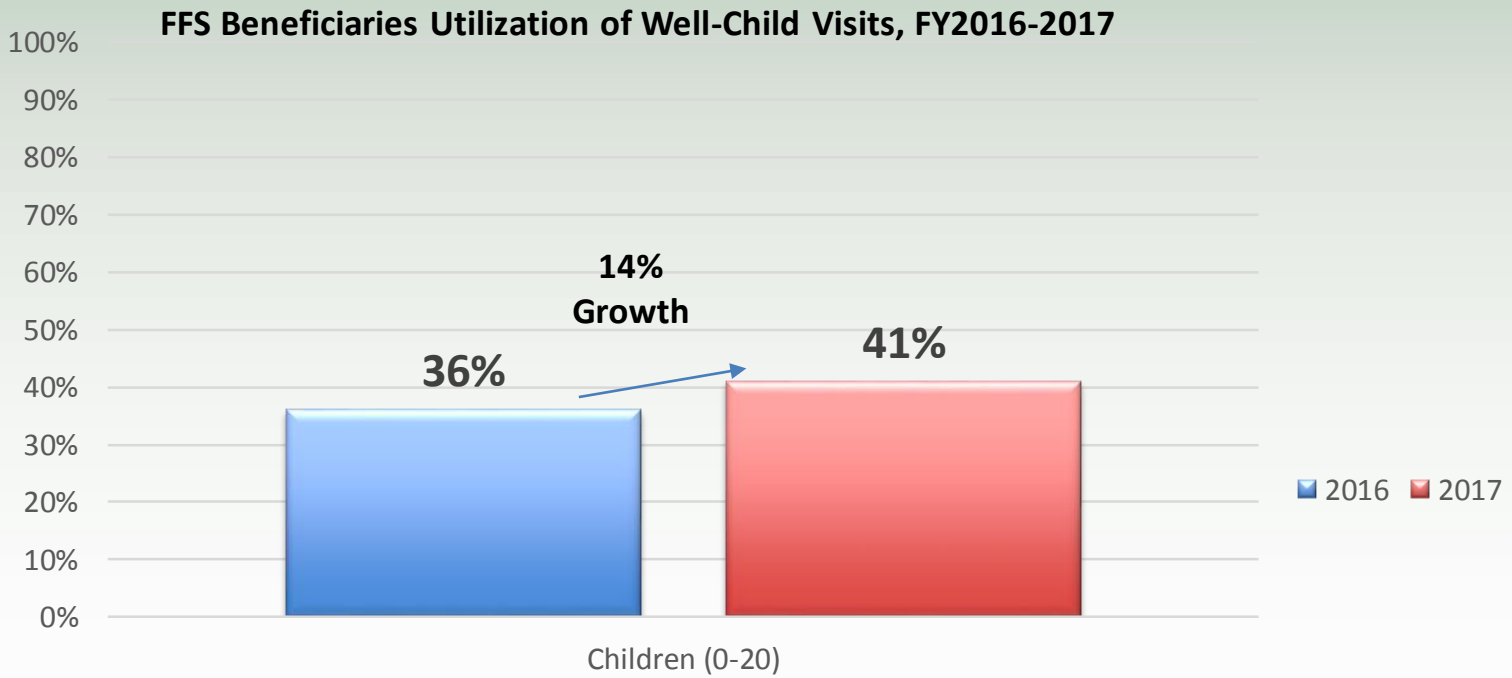
Note: Calculations performed by Mercer Consulting using DHCF capitated payment data and MMIS claims. AmeriHealth's numbers are not final, pending the submission of claims that are presently under review. This may improve the plan's performance.

Fee-For-Service Beneficiaries Make Up Disproportionate Share of Medicaid Expenditures



Source: Data were extracted from DHCF MMIS system. *Only persons with 12 months of continuous eligibility in 2017 are included in this analysis.

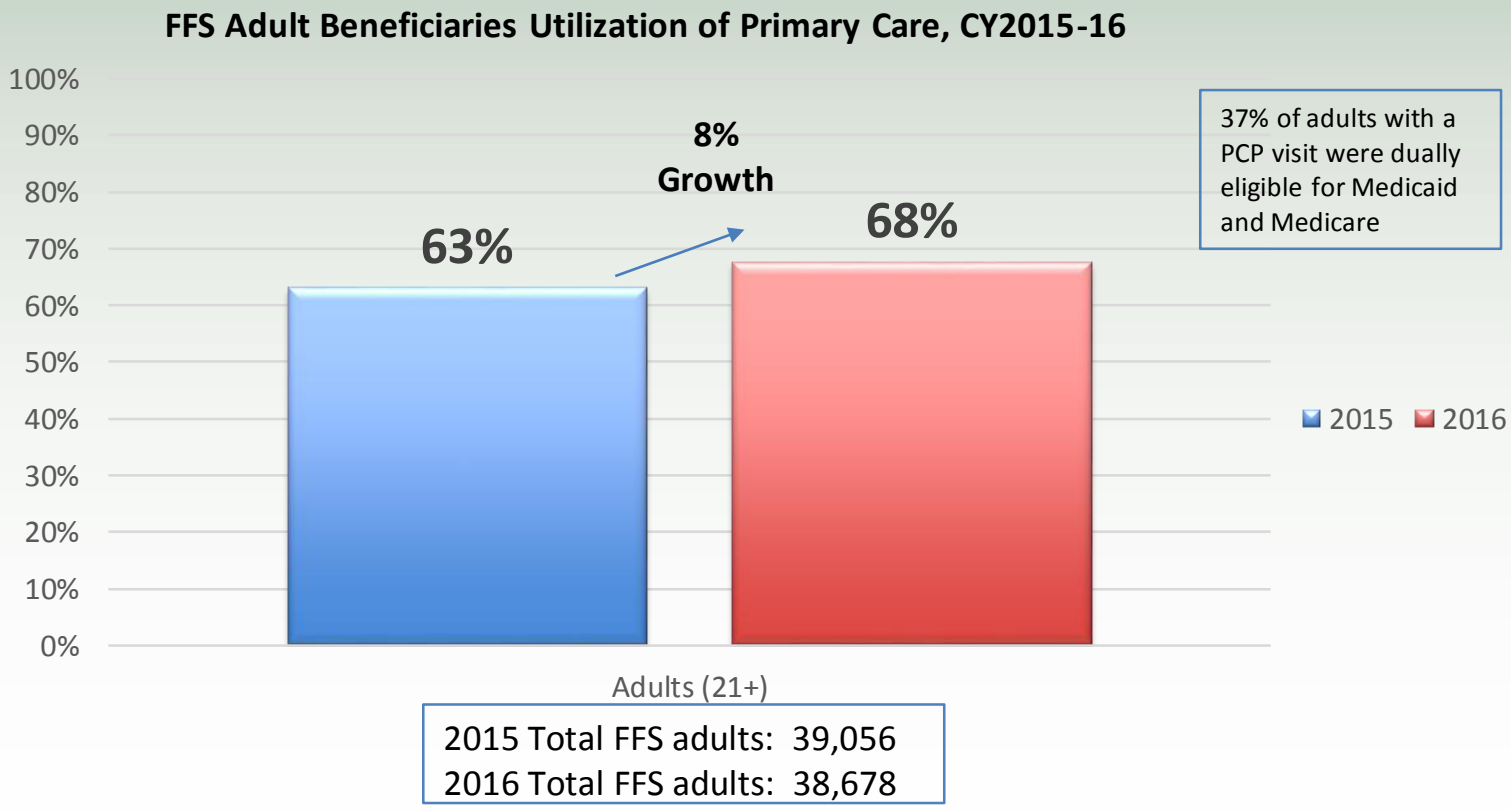
Utilization of Well-Child Visits Growing for FFS Children



2016 Total FFS children:	5,220
2017 Total FFS children:	5,308

FFS beneficiaries were identified as those with >= 3 MTM payments and 0 MCO payments during reporting year.
Data Source: DC Medicaid Management Information System (MMIS) beneficiary data, extracted June, 2017.
Findings for well-child visits were based on data extracted for CMS-416 EPSDT report. FY17 findings are preliminary.

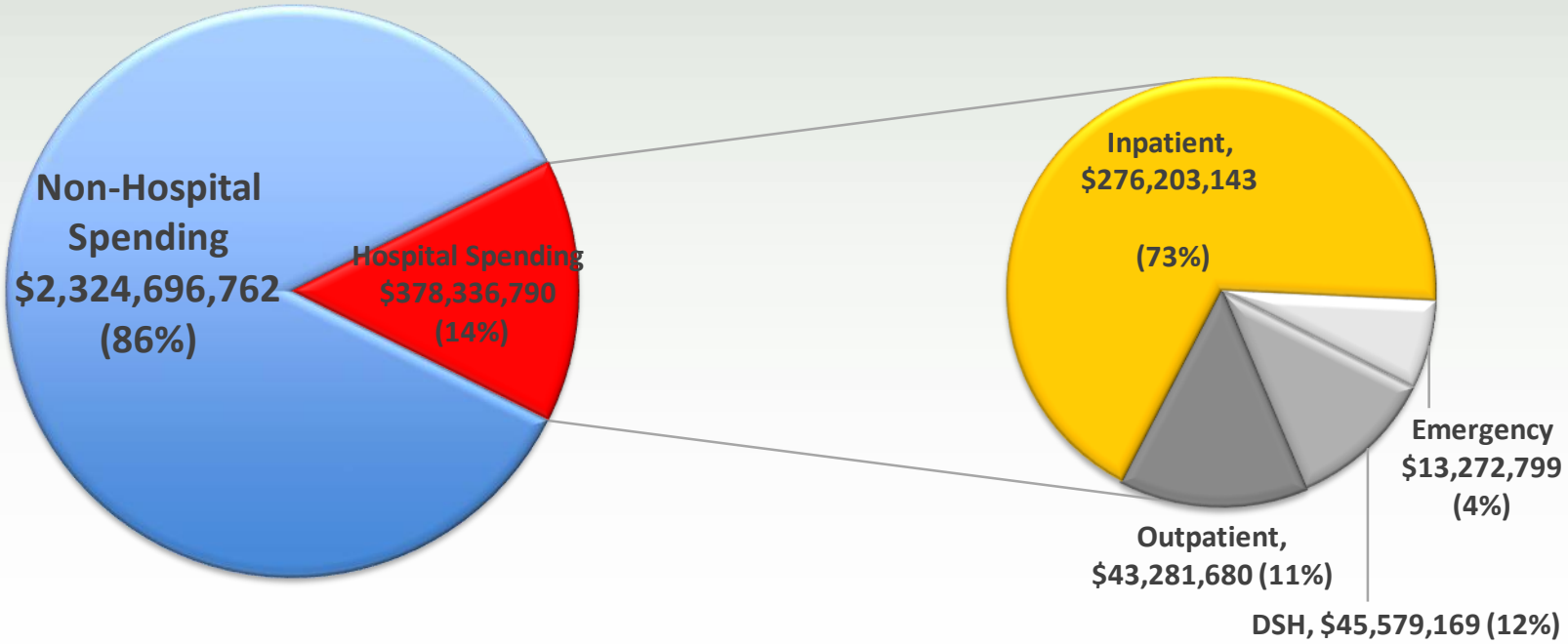
Utilization of Primary Care Growing for FFS Adults



FFS beneficiaries were identified as those with >= 3 MTM payments and 0 MCO payments during reporting year.
Data Source: DC Medicaid Management Information System (MMIS) beneficiary data, extracted June, 2017.

Fee-For-Service Medicaid Hospital Spending Is 14 Percent Of Total FFS Medicaid Expenditures

Total FY2017 Spending
$2,703,033,552



Source: Data extracted from MMIS reflect final claims, including adjustments, and DSH payments made during FY17

The Top 10 Chronic Conditions For Fee-For-Service Beneficiaries Include Hypertension and Behavioral Disorders

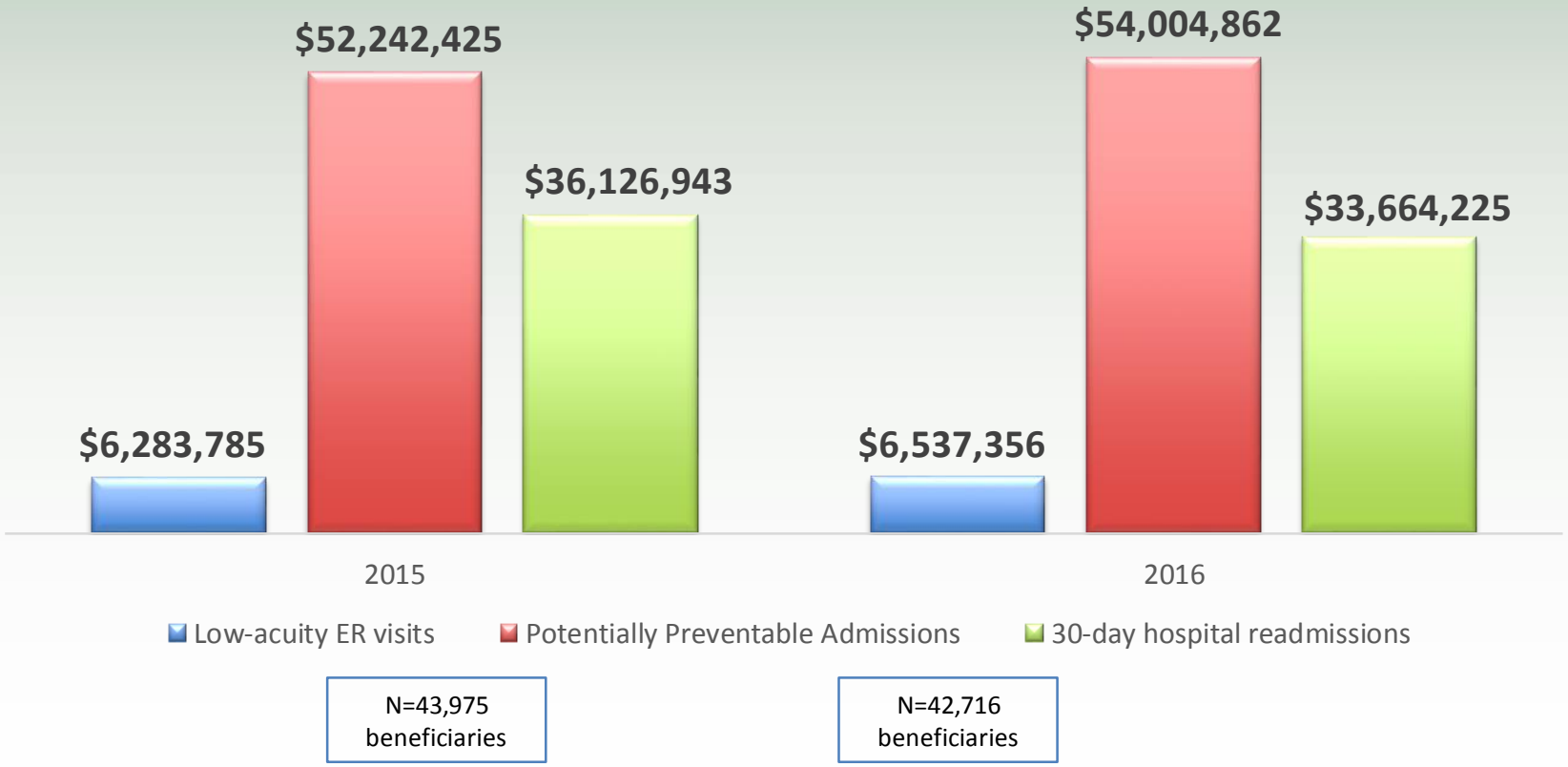
Adults	
Condition	Percent of total
Hypertension	58%
Hyperlipidemia	33%
Diabetes	31%
Personality Disorder	24%
Osteoarthrosis	23%
Asthma	22%
Depression	22%
Obesity	16%
Atherosclerosis	16%
Glaucoma	14%

Children	
Condition	Percent of total
Behavior Disorder*	20%
Asthma	15%
Allergy	14%
Personality Disorder	7%
Depression	7%
Obesity	5%
Anxiety	3%
Congenital	3%
Glaucoma	1%
Hypertension	1%

Notes: FFS beneficiaries were identified as those with >= 3 MTM payments and 0 MCO payments during reporting year.

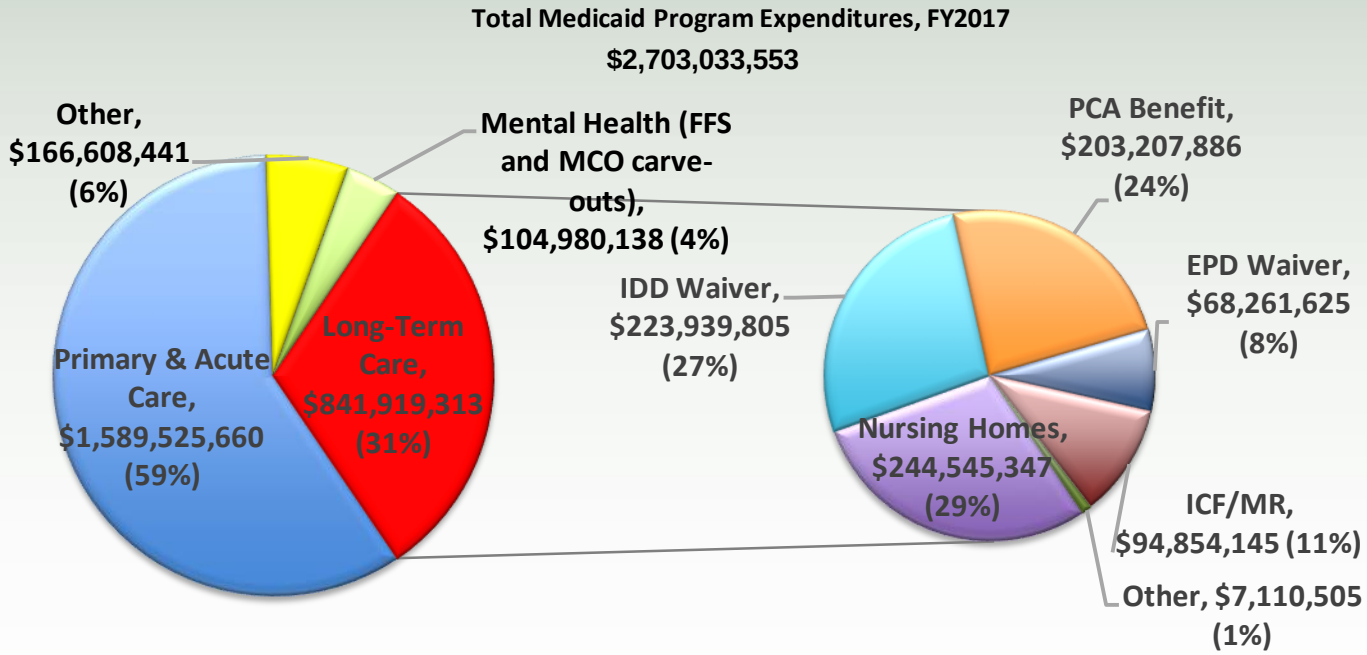
Data Source: DC Medicaid Management Information System (MMIS) beneficiary data, extracted June, 2017. *Examples of behavior disorders include eating disorders, conduct disorders, and attention deficit disorders.

Nearly $100 Million of Annual Costs Incurred For Fee-For-Services Beneficiaries In 2015 And Again In 2016 Was Avoidable



FFS beneficiaries were identified as those with >= 3 MTM payments and 0 MCO payments during reporting year.
Data Source: DC Medicaid Management Information System (MMIS) beneficiary data, extracted June, 2017.

More Than Three In Every 10 Medicaid Dollars Is Spent On Long-Term Care Services



Source: Data extracted from MMIS, reflecting claims paid during FY2017

Consistent With Recent Years, Home and Community Based Services Account for the Largest Share of Long-Term Care Spending

Medicaid Institutional And Waiver Spending, FY17

Program Service	Total Number of Recipients	Total Cost for Services	Average Cost Per Recipient
Nursing Facilities	4,832	$244,545,347	$50,610
EPD Waiver	3,311	$68,261,625	$20,617
State Plan Personal Care	5,795	$203,207,886	$35,066
IDD Waiver	1,905	$223,939,805	$117,554
ICF/MR	329	$94,854,145	$288,310
Total	---	$834,808,808	---

Source: Data extracted from MMIS, reflecting claims paid during FY2017

EPD Waiver Budget Neutrality

April 4, 2017 thru March 23, 2018

The District Offers a Robust EPD Waiver Benefits Package

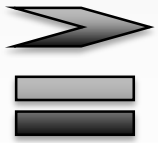
CMS requires that a Waiver program must be equal to or less than the Institutional cost per member in order for the State to maintain the Waiver service.

EPD Waiver Cost Per Person
+
State Plan Services Utilized
=
Total EPD Waiver Cost per Person

NH Rate Cost Per Person
+
State Plan Services Utilized
=
Total NH Cost per Person

The District's Current EPD Waiver to Date

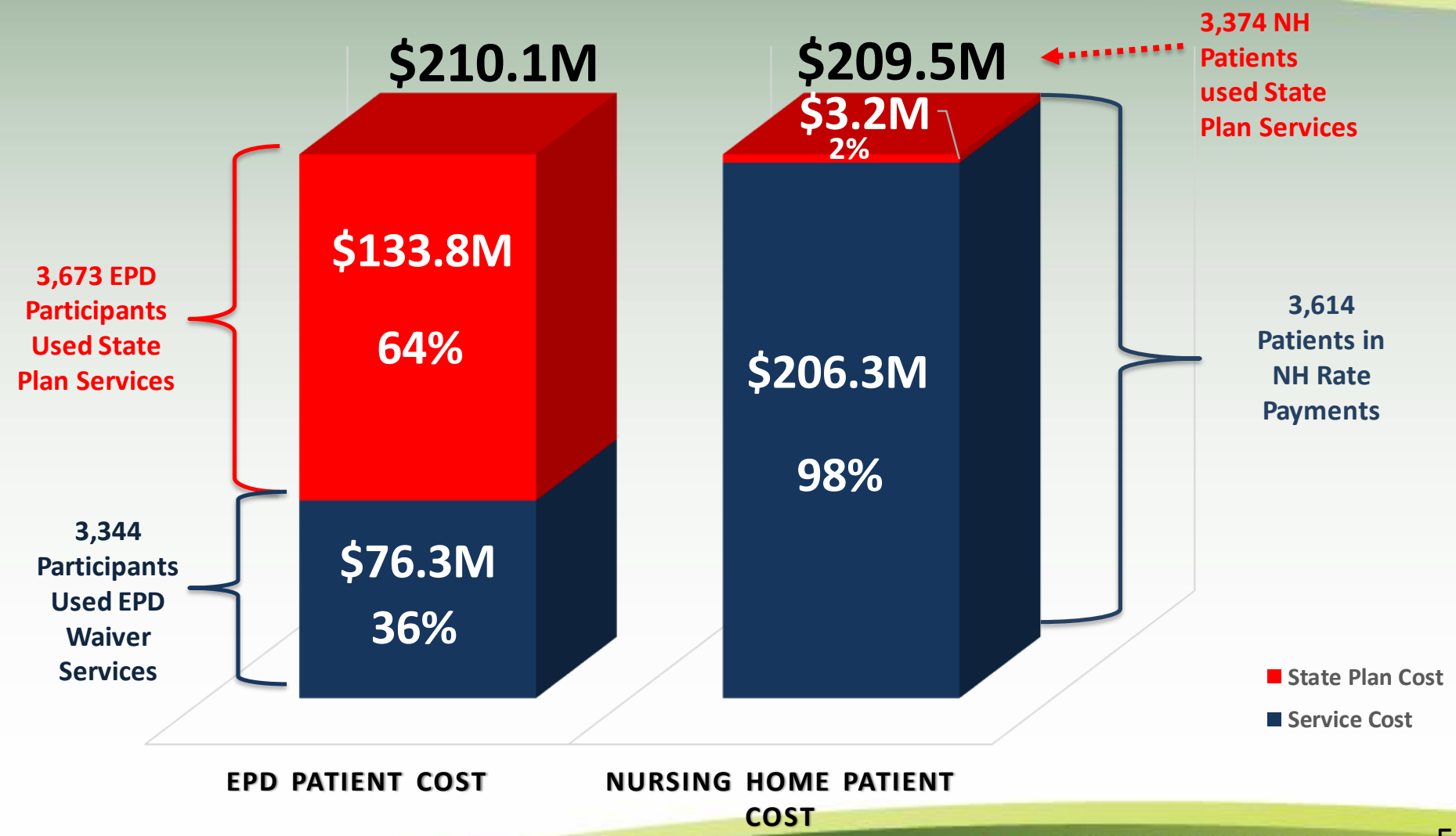
$22,843
+
$36,468
=
$59,312 per person



$57,096
+
$959
=
$58,055 per person

EPD Waiver vs Nursing Home Cost

April 4, 2017 thru March 23, 2018



EPD Waiver Budget Neutrality

EPD Waiver	
EPD Waiver Service Cost	
Assisted Living	1,437,609
Case Management	6,656,983
Participant Directed Services	23,874,516
Personal Care Aide Services	44,003,775
Personal Emergency Response Service	320,530
Respite	94,114
Total EPD Service Cost	**76,387,527**

Nursing Home	
Nursing Home Rate Cost	
Nursing Home Rate Cost	206,345,404

State Plan Services used by EPD Members	
Personal Care Aide Services	100,538,552
Skilled Nursing Visits	4,053,159
Durable Medical Equipment (DME)	7,003,842
All Other Services	22,279,876
Total State Plan	**133,875,429**
EPD Waiver Service Cost	76,387,527
EPD Patient State Plan Cost	133,875,429
Total EPD Patient Care Cost	**210,262,956**

State Plan Services used by NH Members	
Pharmacy	574,062
MCO Cap	536,290
Outpatient/Medicare Part B Crossover	479,992
All Other Services	1,645,557
Total State Plan	**3,235,901**
Nursing Home Rate Cost	206,345,404
NH Patient State Plan Cost	3,235,901
Total NH Patient Care Cost	**209,581,305**

DHCF Leadership Is Making Plans Moving to Preserve the EPD Waiver in the Future

The current Waiver period is April 4, 2017 thru April 3, 2018.

The new Nursing Home rate is effective as of February 1, 2018; increasing the Nursing Home cost and reducing the delta between the two Provider Categories

Potential Service Changes:

1. Allow a total of 16 hours PCA services for participants versus the current 24 hours
2. Review payment methodology for Skilled Care (i.e. bundled vs incremental) and review requirements for Supervisory visit for PCA's
3. Reduce Participant Directed Services administrative budget under the Waiver
4. Amend Waiver to end double billing of PCA services in Assisted Living Facilities
5. Review Case Management responsibilities related to care coordination

The Program of All-Inclusive Care for the Elderly (PACE)

- PACE is a nationally recognized model of care integrating Medicare and Medicaid benefits for some of the District's highest-need beneficiaries: individuals 55+ meeting nursing facility level of care

- In order to launch the program in late FY19/early FY20, DHCF will:

  - Draft a state plan amendment and implement regulations
  - Tentatively select a PACE provider based on responses to an RFI
  - Endorse the provider's application to CMS as a PACE provider
  - Launch enrollment and begin oversight of the program

- The PACE program will launch a single site serving approximately 200-300 eligible individuals living in Wards 7 and 8

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- ❑ Medicaid Program Trends
  - *Managed Care*
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  - *Long-Term Care*
- ☑ **Medicaid Innovations And Potential Future Impacts of Federal Legislation**
- ❑ Next Steps With United Medical Center
- ❑ Conclusion

DHCF Launched My Health GPS Program to Help High-Need Beneficiaries Navigate the Health System

- Key Design Elements Launched on July 1, 2017:
  - Robust care coordination for beneficiaries with 3+ chronic conditions
  - Monthly payment to integrate and coordinate *all* health-related services
  - Includes pay-for-performance component to hold providers accountable
- Goals:
  - Increase health quality and outcomes
  - Reduce preventable utilization of 911/FEMS, avoidable hospital admissions and ER
- Providers: 12 providers with interdisciplinary teams in 33 primary care settings
- Participation: ~3,500 beneficiaries enrolled (55% FFS: 45% MCO)
  - Target Enrollment: ~18,000 beneficiaries by FY2022
- Key Innovations:
  - **Health Information Exchange (HIE) Tools**: First users of three new innovative HIE tools that provides real-time data support care coordination
  - **Individualized Technical Assistance (TA)**: Providing on-site support to all My Health GPS providers to improve delivery of patient-centered care
  - **Transportation Pilot**: Offering transportation to and from medical appointments with any District Medicaid fee-for-service provider with as little as three hours advance notice

Average Beneficiaries Enrolled in My Health GPS Are Older and Account for Higher Spending and Utilization

Characteristic (Based on Claims in FY2016)	All Other Non-Waiver And Non-Institutional Medicaid Adults (n=83,377)	My Health GPS Enrolled Population (n=3,500)
Average Age	39	53
Per-Member Cost	$7,090	$17,622
Average Hospital Admissions (at least one admission)	1.4	2.4
Average Emergency Room Visits	1.2	3.0
Mean Medications Per Person	3.2	14.9
Percent with substance use disorder (SUD)	1.7%	16.1%
Percent living in Wards 7 or 8	38.4%	36.7%

Source: DHCF staff analysis of data extracted from the agency's Medicaid Management Information System (MMIS). Utilization measure are based on claims with dates of service in FY2016. Other Medicaid Adults were defined as beneficiaries age 21 and over with 12 months of continuous eligibility in FY2016. Figures exclude data on persons in nursing homes, intermediate care facilities, and the community-based waiver programs, as well as those determined eligible for My Health GPS.

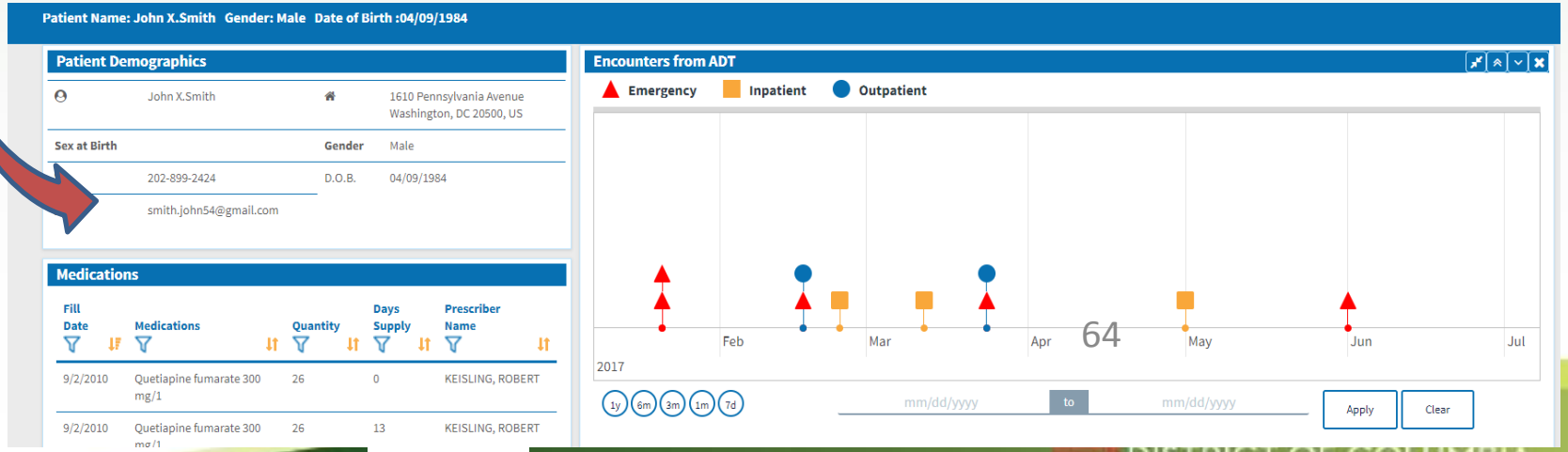
My Health GPS Enrollment and Spending*

Provider	Enrolled Members	DHCF Paid Amount
BREAD FOR THE CITY	78	$37,539.80
CHILDREN'S NATIONAL MEDICAL	83	$40,443.61
COMMUNITY OF HOPE	209	$105,283.29
FAMILY AND MEDICAL COUNSELING	5	$322.40
LA CLINICA DEL PUEBLO	71	$33,433.51
MARY'S CENTER FOR MATERNAL	184	$75,445.08
MEDICAL HOME DEVELOPMENT GROUP	127	$65,052.95
PROVIDENCE HEALTH SERVICES	815	$427,391.87
UNITY HEALTH CARE	1643	$804,244.98
WHITMAN-WALKER CLINIC	285	$139,667.79
TOTAL	**3,500**	**$1,728,825.28**

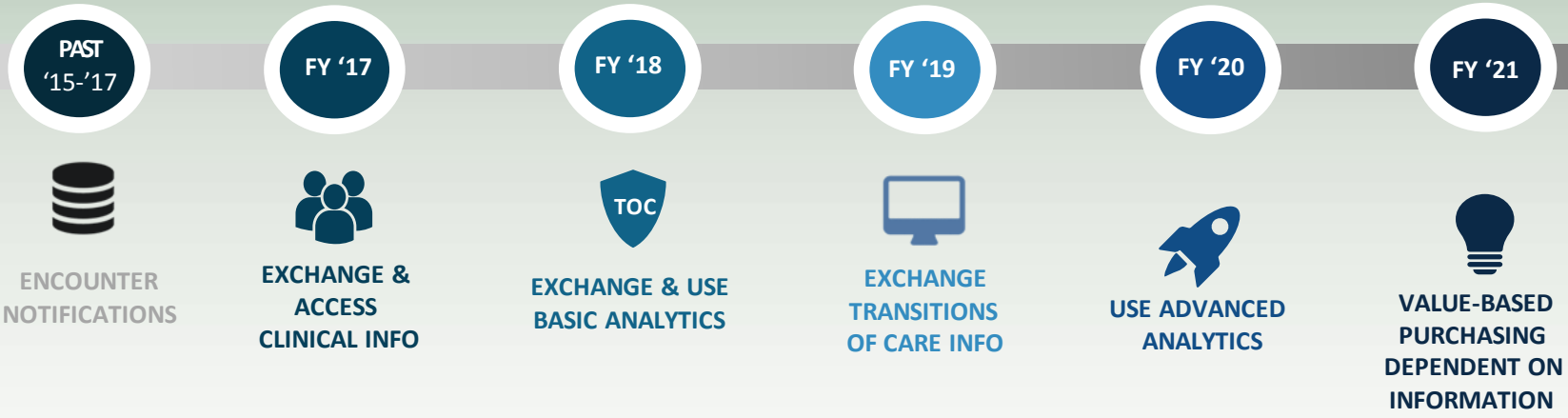
*July 1, 2017 - February 21, 2018

My Health GPS Providers Are First to Use New *Health Information Exchange* Tools

1. Patient Care Snapshot ⟹ know your patient
2. Population Health Analytics ⟹ know your panel
3. Clinical Quality Measures Dashboard ⟹ know your quality scores
4. Obstetrics/Prenatal Specialized Registry ⟹ ease reporting /payment
5. Supporting Connectivity to HIE Tools and T/A ⟹ get connected



Health Information Exchange Capabilities Will Grow to Support Better Quality and Higher Value Care



DHCF is looking ahead at opportunities to help providers exchange information and improve care transitions.

Plans are informed by over 30 stakeholder interviews, HIE Policy Board meetings and focus groups, including with:

- Beneficiaries
- My Health GPS Providers
- MCOs
- Primary Care Providers
- Long-term Care Facilities
- Hospitals

Investments in Telehealth Infrastructure

- 2018 BSA authorized grants to support telehealth services in two focused areas:
  - Wards 7 and 8 – Three $50,000 grants awarded in March, 2018 to :
    - Accent on Health
    - Medical Home Development Group
    - Unity
  - Homeless Shelters and Public Housing Projects - $75,000 grants will be awarded to two organizations in Spring, 2018
- How do we learn from these innovative projects?
  - DHCF will lead an optional learning collaborative for six grantees to discuss best practices and improve during the grant period
  - DHCF will host public meeting in Fall 2018 to highlight successes and lessons learned from telehealth grants

Innovations Made In Nursing Home Payment Methodology

- New Nursing Facility Rates Developed, Effective 2/1/18
  - Prospective rates promote transparency and predictability
  - Patient-specific rates based on patient acuity levels and needs incent nursing facilities to care for higher needs patients:
    - Use updated RUG IV case-mix measurement tool
    - Add-on payments for special needs patients with ventilator, bariatric or behavioral health needs

- Three new nursing facility peer groups:
  - Hospital-based
  - Small
  - Large

- Rates will be rebased every four years
  - Quality Incentive Improvement Program Improves DHCF Quality Oversight
  - Mandatory quality reporting on nationally recognized metrics for all facilities
  - Voluntary pay-for-performance program for nursing facilities that opt in and show improvement on key metrics

Nursing Facility Quality Improvement Program

- DHCF goals:
  - Improve the quality of care and quality of life for nursing facility residents
  - Incorporate a performance incentive as a first step toward value-based purchasing for nursing facility services
  - Ensure infrastructure, resources and supports are in place to facilitate success to future quality improvement and payment reform initiatives

- Principles guiding measure development:
  - Build on best practices from other states & CMS
  - Align with existing measures/reporting to reduce burden and confusion – 7 of 15 measures also reported to CMS
  - Focus on care transitions similar to other DHCF initiatives

- Design: Nursing Facilities will receive a bonus payment based on their performance in four (4) quality performance domains:
  - Quality of Care
  - Quality of Life
  - Utilization
  - Infrastructure

FY 2017 Quality Initiatives

- Pay for Performance Programs Implemented
  - MCO
  - Nursing Homes Initiative
  - FQHC Initiatives
  - My Health GPS
- EQRO Contract Renewed
-
  - CMS required activities
  - Additional activities
    - Satisfaction Surveys for State Plan Beneficiaries
    - Additional Performance Measure Validation for My DC Health Home
    - MCO Report Card
    - Network Adequacy Validation
- Performance Measure for My DC Health Home Developed

DHCF Medicaid Data Warehouse (MDW) Will Enhance Agency Analytical and Reporting Capabilities

- DHCF commenced a MDW project in January of 2014 to replace the legacy system with a modern state-of-the-art data warehouse. With the new system in place users now have access to:
  - More years (at least 14) of enrollment, claims and utilization data;
  - Easy-to-use business intelligence (BI) tools to perform their own analytics;
  - Pre-built interactive subject-specific reports and dashboards (enrollment, provider, recipient, utilization, spending, budgeting, forecasting and predictive analytics)
  - Interoperability and the ability to ingest and integrate external data files to provide a more comprehensive profile of our beneficiary population;
  - More timely local and federal reporting capability
- The MDW had its formal go-live on September 30, 2017 with an impressive array of high performance reports, dashboards and functional features that can now meet most of the analytical data needs of the agency.
- The MDW project has targeted May 31, 2018 to complete the requirements for a successful validation process and complete certification by June 30, 2018.
- The system was built at a relatively modest cost of $10.7 million through FY2018 compared to most state Medicaid data warehouse projects that exceed $25 million.

Federal Legislation:
Recent Reforms with Implications for Medicaid/CHIP

- **Bipartisan Budget Act:**

❑ Delayed DSH Cuts Scheduled for FY18 & FY19

- ➢ Under new requirements, $4B cut to federal Medicaid DSH payments scheduled to begin in FY20
- ➢ DSH cuts will increase to $8B per year for FY21-25

❑ Established New Rules for Treatment of Lottery/Lump Sum Payments:

- ➢ Lottery, sweepstakes, pool winnings or lump sum income counted as monthly income for MAGI eligibility - rules vary based on amount
- ➢ Doesn't affect eligibility for household members

- **Tax Cuts and Jobs Act:**

- ➢ Reduced health insurance individual mandate penalty to $0, effective 1/1/19 – risk of decreased private coverage enrollment could impact Medicaid enrollment

Federal Legislation: CHIP Reauthorization Update

- Federal CHIP legislation extended funding through FY27
  - Stop-gap funding measure (HR 195) extended funding through FY23
  - Bipartisan Budget Act (HR 1892) extended additional 4 years, through FY27
- Key policy changes to CHIP
  - Reduced federal matching rate (FMAP), beginning in FY20 –
    - FY18-19: 100% FMAP
    - FY20: 90.5% FMAP
    - FY21-27: 79% FMAP (Historic CHIP rate)
- Additional local share will require $3.9 million in DHCF local allocation, beginning in FY20 –
- Reduced mandatory eligibility levels for children under "maintenance of effort (MOE)" requirements, from current eligibility levels (319% FPL in DC) to 300% FPL, beginning in FY20

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Current UMC: The Need For Operating and Capital Subsidies Continues In FY2018 And Also In The Mayor's FY2019 Budget

- Fiscal pressures in FY2018 required the Mayor to allocate $23.7 million to support UMC hospital operations including funding to defray the cost of –
  - Medicare recoupment for violation of two-midnight rule
  - New operator's contract for Mazars
  - Contracts with George Washington Medical Faculty Associates to operate the hospital's emergency and inpatient departments
  - Nurses arbitration award
  - Cash reserves for the hospital
- In her FY2019 proposed budget, the Mayor is allocating $10 million to support UMC operations
- In her FY19-24 proposed capital budget, the Mayor is allocating $14.3M for UMC Improvements, with $4.5M identified for FY 19

The Six-Year Capital Funding Plan - A New Hospital at St. Elizabeths East (in millions)

Last Year's Approved FY18-23 "East End" Hospital Capital Budget		Mayor's Proposed FY19-24 Capital Budget*						
		New "801 East" Emergency Housing	St. E's Campus Infrastructure	Garage 2 – ESA Parking	A New Hospital at St. E's East Planning and Design	Hospital, Ambulatory and Garage 1 Construction	Sub Total Hospital, Ambulatory and Garages	To speed up hospital we increased pace of funding compared to FY18-23
FY18	$0.0	N/A	$15.0	N/A	N/A	N/A	N/A	N/A
FY19	$0.0	**$18.0**	**$14.0**	$3.0	$4.0	$2.0	**$9.0**	+$9.0
FY20	$0.0	**$22.0**	**$20.0**	$18.0	$8.0	$20.0	**$46.0**	+$46.0
FY21	$10.8	-	**$35.0**	-	$8.0	$64.0	**$72.0**	+$61.2
FY22	$83.0	-	**$35.0**	-	$3.0	$84.0	**$87.0**	+$4.0
FY23	$206.2	-	-	-	-	$35.0	**$35.0**	-$171.2
FY24	N/A	-	-	-	-	$51.0**	**$51.0****	+$51.0
Total	**$300.0**	**$40.0**	**$104.0**	**$21.0**	**$23.0**	**$256.0**	**$300.0**	

- The FY19-24 outlay represents the New Hospital at St. Elizabeths East opening in calendar year 2023.
- The $51M in FY24 gives the District the flexibility needed to address the final hospital size, design, contingencies in construction, and medical equipment based on lines of service.
- The St. Elizabeths East Campus Infrastructure costs includes roads, sewer, water, fiber and stormwater facilities.
- The District intends to replace the 801 East Men's Shelter with a state-of-the-art facility designed for specialized programming, increased support services, and enhanced privacy and security.

Key Elements Of Plan For New Hospital

- The comprehensive plan for the new hospital envisions the following:
  - Hospital cost - $250 to $265 million
  - Number of beds - 100 to 150

- Site size will consume 270,000 to 350,000 square feet and support –
  - Inpatient building
  - Ambulatory pavilion
  - Diagnostic and Treatment services
  - Building and logistical support
  - Office space
  - Public space
  - Two garages

- Planning and design will begin in FY2019

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- ❑ Next Steps With United Medical Center
- ☑ **Conclusion**

Conclusion

- The Mayor's proposed budget makes no changes to Medicaid and Alliance beneficiaries' eligibility, thus preserving the District's strong tradition of coverage
- The Mayor's budget fully funds the contracts for the District's Medicaid managed care plans – health plans that are now required to meet specific performance metrics on three key indicators designed to measure improvement in patient outcomes
- Similarly, the Mayor's budget adequately funds DHCF's fee-for-service program which serves Medicaid's most fragile and highest cost beneficiaries
- In FY2018, DHCF will offer a new program -- My Health GPS -- that is designed to empower providers to implement strategies that improve care and patient outcomes for beneficiaries who are chronically ill
- This program will be implemented concomitant with DHCF efforts to improve long term care services and supports through the EPD Waiver renewal
- Finally, for the first time since UMC was purchased by the District in 2010, the Mayor has allocated sufficient funding in the six-year plan to build a new hospital by no later than FY2024 and possibly sooner.